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ABSTRACT

This book provides information about emotional, behavioral, learning and developmental disabilities; disability-specific entitlements; and approaches for professionals who work with youthful offenders with disabilities throughout the juvenile process. Chapter 1 describes characteristics of common disabilities among youthful offenders and details strategies and accommodations that professionals may want to consider when working with the youth who have these disabilities. Disabilities described include conduct disorder, depression, post traumatic stress disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, learning disabilities, and developmental disabilities. Case studies of individuals with different disabilities are provided, as well as a list of some of the communication difficulties confronted by individuals with mental retardation. Chapter 2 reviews entitlements for youth with disabilities in the justice system, including rights under the Individuals with Disabilities Education Act (IDEA). This chapter also discusses school discipline policies and rules that could discriminate against specific students. Strategies that professionals can use for promoting family involvement are outlined in chapter 3. A final chapter makes recommendations for overcoming the barriers in the juvenile justice system that make it more difficult for youth with disabilities to receive appropriate and meaningful correctional responses. An appendix provides a resource list of national organizations related to youth and juvenile justice and a list of parent training and information centers. (Contains 64 references.) (CR)

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Unique Challenges, Hopeful Responses

A Handbook for Professionals Working with Youth with Disabilities in the Juvenile Justice System

EC 305981

PACER Center, Inc.

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Unique Challenges, Hopeful Responses

A Handbook for Professionals Working with Youth with Disabilities in the Juvenile Justice System

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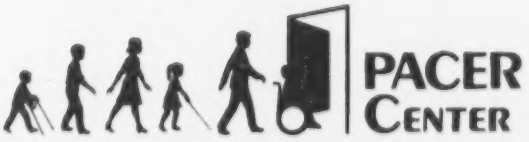

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Contents

Preface 2

Introduction 3

Chapter I
Common Disabilities Among Youthful Offenders: Accommodations in the Justice Process 6

Conduct Disorder 7
Working with Youth who have Conduct Disorders 10

Depression 13
Working with Youth who have Depression 14

Case Study: Allie 17

Post Traumatic Stress Disorder 18
Working with Youth who have Post Traumatic Stress Disorder 18
Working with Youth who have Conduct Disorders, Depression and Post Traumatic Stress Disorder .. 19

Attention Deficit/Hyperactivity Disorder (ADHD) 20
Working with Youth who have Attention Deficit Hyperactivity Disorder 21

Case Study: Jeff 24

Oppositional Defiant Disorder 25
Working with Youth who have Oppositional Defiant Disorder 25

Learning Disabilities 27
Working with Youth who have Learning Disabilities 29

Developmental Disabilities 31
Working with Youth who have Developmental Disabilities 34

Communication Difficulties Confronted by Individuals with Mental Retardation 37

Questions to Ask If You Suspect a Defendant Has Mental Retardation 38

Case Study: Ben 39

Chapter II
Entitlements for Youth with Disabilities in the Justice System: Individuals with Disabilities Education Act (IDEA) 40

Discipline in the Schools 49

Chapter III
Promoting Family Involvement 54

Chapter IV
Systems & Services: Looking to More Hopeful Responses 58

Systems' and Service Needs 58
Recommendations for More Hopeful Responses 59

Conclusion 62

Appendix

Resource List of National Organizations Related to Youth and Juvenile Justice 63
References 66
Parent Training and Information Centers 71

Preface

In 1994, PACER Center began its project on Youth with Disabilities in the Juvenile Justice System. Interest in the needs of this population originated in PACER's Abuse Prevention Project, where staff found a distinct link between child maltreatment and subsequent criminal behavior. Also, PACER advocates documented an increasing number of requests for assistance regarding the special education needs of adjudicated youth. With assistance from The McKnight Foundation and the Jay and Rose Phillip Family Foundation, PACER initiated an examination of the unique needs of young offenders with disabilities within the context of current theory and research regarding juvenile delinquency.

Parents, professionals, and organizations like PACER continue to strive for a more thorough understanding of youth with disabilities who are over-represented in the juvenile justice system. This book is intended to encourage those working with youth to consider approaches that are both rehabilitative and disability-sensitive. Drawing upon PACER's history of serving youth with disabilities on a range of issues, this book can be used as a guide to address the unique disability-related needs of those young persons involved in the justice system.

Introduction

Youth with disabilities are represented in the juvenile justice system in numbers disproportionate to their incidence in the general population.

Most youth with disabilities do not develop criminal behavior. However, youth with emotional and behavioral disorders, learning disabilities, and developmental disabilities are represented in the juvenile justice system in numbers disproportionate to their incidence in the general population. It may be that more than half, or as much as 90 percent, of youth in the justice system meet the diagnostic criteria for one or more disorders (Nelson, 1995; Otto, 1992). A 1995 survey of adolescents in corrections settings and adolescents in public schools indicates that more than twice as many of the adolescents in corrections had been placed in special education classes for learning problems (Harrison, Fulkerson & Beebe, 1996). In fact, another study has determined that over 98 percent of juvenile offenders entering adult correctional facilities were high school dropouts (Ingersoll & LeBoef, 1997).

While the presence of a disability is not an excuse or rationalization for unlawful activity or an exemption from consequences, it *does* mean:

- If a youth's behaviors are characteristic of a disability, he or she may require a disability screening and evaluation;
- If a youth's disability interferes with his or her capacity to participate meaningfully in the justice process, he or she has a right to have the proceedings adapted to the needs stemming from the disability; and
- If there is a formal diagnosis of a disability, a youth may be entitled to specific services relative to the disability while in a correctional program, including aftercare.

Issues regarding youth with disabilities involved in the juvenile justice system are complex and interconnected, requiring the expertise and cooperation of professionals from many different fields. In addition, appropriate treatment requires that professionals have an understanding of diverse systems, cultures, laws, and approaches to working with youth at risk (Benjamin, 1997). To participate effectively as members of multidisciplinary teams, all must share at least a basic understanding of the many issues that can have an impact on a youth's life. Questions to consider include:

- What are the characteristics of a specific disability, and how do they affect typical functioning for the youth? Might illegal behavior, or charges of illegal behavior, relate to the presence of a disability?

- How can the youth with a disability be appropriately served in school, in court, or in a correctional setting?
- Has the youth been attending school regularly? Did he or she receive special education and related services while in school? Is there an Individual Education Program (IEP) Plan or other education plan, and does it need to be reviewed?
- Has medication been prescribed and monitored? Is medication currently being used?
- Does the youth have mental health issues such as substance abuse or depression?
- What is family life like for the youth? Has he or she been abused or neglected? Has he or she witnessed domestic violence or violence in his or her neighborhood?
- Have the youth's needs been assessed and addressed using culturally competent approaches? Has someone from the youth's race or culture contributed to the assessment and case planning processes?
- What resources are available to the youth, the family, the correctional program and the community?

Research has well documented that child abuse and neglect, domestic abuse, poverty, substance abuse, racism and community violence are common risk factors among all juvenile offenders.

The issues are many and, individually or combined, can significantly affect the life of a youth. Research has well documented that child abuse and neglect, domestic abuse, poverty, substance abuse, racism and community violence are common risk factors among all juvenile offenders (Blumstein, 1995; Earls, 1991; Harrison, Fulkerson & Beebe, 1996; Hernandez *et al.*, 1993; *Survey* in MHNA, 1996).

Professionals working with juvenile offenders with disabilities must also be aware of the potential impact risk factors may have on a youth and on desired correctional outcomes. Multi-dimensional approaches may be necessary to lessen the effects of multiple complex risks faced by many young offenders. Individual Service Plans (ISP's), IEP's, "wraparound"* and other integrated service approaches are some ways to address multiple issues from a variety of perspectives. Specific interventions include multisystemic therapy, which examines the youth's experience in all of his or her environments, and restorative justice, which focuses on the youth's making reparation for his or her offenses. Working with an understanding of the unique needs of a youth with a disability in the justice system, professionals can more effectively apply their expertise within a comprehensive context of each youth's life.

*"Wraparound" services are coordinated services across agencies that are provided in the child's normal environment whenever possible.

This book includes information about emotional, behavioral, learning and developmental disabilities; disability-specific entitlements; and approaches for professionals who work with youthful offenders with disabilities throughout the juvenile justice process. These professionals include law enforcement officers; prosecutors; defense attorneys; probation officers; dispositional advisors; juvenile court referees and judges; city, county and residential corrections staff; employers and work-release staff; social service and mental health providers; special and regular education professionals; advocates; and clergy and other religious leaders.

This information can be utilized at each step in the juvenile justice process including those formal proceedings that:

a) *investigate* a youth's possible involvement in a delinquent or criminal offense, including intake and interrogation;

b) *result in arrest* of a youth suspect;

c) *determine* whether charges will be made against a youth;

d) *decide* if a case is referred to juvenile court or to an alternative or diversion program;

e) *adjudge* a youth's innocence or guilt;

f) *develop* correctional interventions or consequences;

g) *select* the setting(s) in which correctional programming will take place; and

h) *provide for* implementation and monitoring of the correctional case plan.

The following chapters focus on those disabilities most common among juvenile offenders that can be addressed in special education law through the Individuals with Disabilities Education Act (IDEA). There is a range of disabilities not addressed in this publication but also present among adjudicated youth including traumatic brain injury (TBI), pervasive developmental disabilities (PDD) and anxiety disorders. For more information, see the Appendix or contact PACER Center.

Chapter I

Common Disabilities Among Youthful Offenders: Accommodations in the Justice Process

With adequate information about the range of disabilities common among youthful offenders, professionals can provide meaningful interventions and appropriate accommodations to them within the justice system. However, there are no definitive responses. Each youth manifests a disability in ways that are unique to that youth. Many youth with disabilities also have additional coexisting disabilities, compounding the challenges experienced by professionals working with them. Combined with the impact of other risk factors in a youth's life, disabilities in this population are among the most difficult to identify, diagnose, treat and respond to effectively.

The Americans with Disabilities Act (ADA), Title II, prohibits state and local governments from discriminating against people on the basis of a mental or physical disability. State and local court systems are required not to discriminate against people with disabilities. It is important that court personnel, attorneys, and judges understand that reasonable accommodations must be made in policies and practices to ensure that an individual is not subject to discrimination based on disability.

The most common disorders among youthful offenders in the justice system include conduct disorder, depression, attention deficit/hyperactivity disorder (ADHD), learning disabilities (LD), post traumatic stress disorder (PTSD), and developmental disabilities (DD), including mental retardation and autism. Common characteristics of these disabilities, and approaches and accommodations professionals may consider when working with youth who have these disabilities, are discussed in the pages that follow.

Conduct Disorder

Conduct Disorder is the most commonly diagnosed behavioral disorder among delinquent youth. Although conduct disorder is not specifically addressed in the Individuals with Disabilities Education Act (IDEA), a number of studies have shown that between one third and one half of all youth diagnosed with conduct disorder also have coexisting diagnoses of attention deficit hyperactivity disorder and learning disabilities (Barkley, 1997; Shamsie *et al.*, 1996). However, they may qualify for special education services because these disorders interfere with their learning and their behaviors. At least half of the youth in correctional institutions are believed to have conduct disorder (Nelson, 1995; Otto, 1992).

According to the 1994 edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM IV*):

". . . the essential feature of Conduct Disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age appropriate societal norms or rules are violated... These behaviors fall into four main groupings: aggressive conduct that causes or threatens physical harm to other people or animals... nonaggressive conduct that causes property loss or damage, deceitfulness or theft and serious violation of rules. The behavior pattern is usually present in a variety of settings such as home, school and community."

Depending on the level of severity (mild, moderate or severe conduct disorder), a youth with conduct disorder may engage in a range of behaviors, including some that cause relatively minor harm to others. Some youth may have difficulty feeling or expressing remorse for misbehavior and often will not take responsibility for their actions. Destruction of property can include vandalism and arson. Deceitful behaviors can include lying, theft, shoplifting and forgery. Other features of this disorder can include bullying, threatening or intimidating behavior, extortion, initiation of physical fights, cruelty to animals and cruelty to others perceived as weaker. Physical violence can include rape and sexual assault (Cantwell, 1994; *DSM IV*, 1994; Walker, 1995).

Typically, a youth with conduct disorder misreads social cues and misinterprets the typical actions of others as being aggressive. For example, if someone accidentally bumps into him or her, the youth may shove back. He or she is likely to have assumed the bump was

intentional, thus justifying an aggressive response. Additionally, the youth may perceive hostility in others' behaviors and in situations where typical peers would not.

A youth with conduct disorder may also experience frequent conflict in interactions with those in authority as well as with peers, with conflicts escalating routinely. He or she has limited tolerance for frustration, tendencies toward impulsive and risky behaviors and frequent temper outbursts. These behaviors are often repeated in multiple environments.

Because of these aggressive and destructive behaviors, a youth with conduct disorder may be rejected by his or her peers. The resulting ostracism and social isolation can lead to seeking out peers with behaviors similar to his or her own. (August, 1995; Walker, 1995)

According to *DSM IV* (1994):

"Conduct Disorder is often associated with early onset of sexual behavior, drinking, smoking, use of illegal substances, and reckless and risk taking acts. Suicidal ideation, suicide attempts and completed suicide occur at a higher than expected rate in this group... Academic achievement, particularly in reading and other verbal skills, is often lower than the expected level based on age and intelligence and may justify the additional diagnosis of a learning or communication disorder."

Males with conduct disorder typically exhibit more aggressive behaviors than their female counterparts. These can include school discipline problems, fighting and stealing. Females typically run away from home, use drugs and engage in prostitution (August, 1995; *DSM IV*, 1994; Walker, 1995).

Conduct disorder can be divided into two types:

1. **Childhood Onset, or Early Starter**, diagnosed as young as three- or four-years-old. These youth have at least one characteristic of conduct disorder before age ten and have met the criteria for this diagnosis before puberty.

2. **Adolescent Onset, or Late Starter**. These youth, whose defiant behaviors emerge in early adolescence, exhibit no diagnostic criteria for conduct disorder before age ten (August, 1995; *DSM IV*, 1994).

Childhood Onset (Early Starter) Conduct Disorder

A child as young as age three with behaviors typical of conduct disorder is more likely to continue the behaviors throughout childhood and into adolescence at a higher frequency and a more severe level of delinquency (Earls, 1991). Developmentally inappropriate aggressive behaviors may become apparent on the playground and surface during attempts at early problem solving and negotiating. Common behaviors include severe temper tantrums, whining, hostility towards school and authority figures and not cooperating with rules (Arllen *et al.*, 1994; Cantwell, 1994; Robins, 1991). Youth with conduct disorder diagnosed since early childhood, predominantly male, are most difficult to treat once they have become seriously involved in criminal behavior (Barkley, 1997; Constantino, 1992; Earls, 1991).

Adolescent Onset (Late Starter) Conduct Disorder

Youth whose conduct disorder manifests in adolescence differ from early starters in the following ways:

- They tend to be less aggressive and nonviolent;
- Their behavior does not persist over a long period of time;
- They relate better with peers and their family than do early starters;
- They are represented equally among both males and females;
- Their illegal behavior is more closely linked to impulsivity, defiance and the influence of peer pressure;
- Their families have fewer chronic problems; and
- They are more amenable to interventions such as mentoring and community involvement programs (August, 1995; Bloomquist, 1996; Walker, 1991, 1995).

In both types of conduct disorder, it is common to have coexisting disorders, including attention deficit hyperactivity disorder (ADHD), depression and learning disabilities (Barkley, 1997; Offord, 1994). According to Shamsie *et al.* (1996), approximately 35 percent of youth with conduct disorder also have ADHD and reading disabilities.

Multiple studies of youth diagnosed with conduct disorder at a young age reveal that the diagnosis remains stable over time (Offord, 1992; Walker, 1991). For example, in one study 45 percent of those with conduct disorder at ages four through 12 still qualified for the diagnosis four years later. Nearly half also had one or more additional psychiatric disorders (Offord, 1992).

Youth with conduct disorder for whom treatment has not been successful may grow up to exhibit the adult form of conduct disorder known as Antisocial Personality Disorder. Most studies of chronic and dangerous adult offenders indicate that they are diagnosed with Antisocial Personality Disorder in addition to other serious mental health problems (Robins, 1991). Antisocial behaviors may be ameliorated when early intervention strategies involving the family, school and peers are applied (Barkley, 1997; Shamsie, 1996; Walker, 1995).

Working with Youth who have Conduct Disorders

Youth with conduct disorder, particularly from the age of 14 years, can be among the most difficult youth with whom to work. Their behaviors can be defiant, resistant, destructive, manipulative and dishonest, and it can be a challenge to reach out to them.

Youth with conduct disorder... can be among the most difficult youth with whom to work. Their behaviors can be defiant, resistant, destructive, manipulative and dishonest, and it can be a challenge to reach out to them.

As a youth with conduct disorder tends toward conflictive interactions in more than one environment, those working with him or her should avoid engaging in the conflict a youth may attempt to create. Professionals may experience their interactions to be marked by lies, emotional outbursts and apparent lack of remorse for any misbehavior. A youth with conduct disorder may misread a professional's attempts to assist him or her throughout the justice process and will often exhibit frustration at each step. Professionals need to keep in mind that these behaviors may be manifestations of a disability. With firmness and consistency, professionals can instead focus on assisting the youth to have a clear understanding of the justice process, their options, consequences for misbehavior, and correctional goals based on building academic skills, functional life skills and family and community relationships.

When working with a youth with conduct disorder:

- Anticipate the behaviors common to conduct disorder and purposefully address them in developing corrections and probation plans.
- Clearly establish your professional role with the youth: Why are you working with him or her? Why do you need information from the youth, and what will you do with it? Be honest about his or her potential options throughout the justice process.
- Set clear, specific limits on behaviors, explain that behaviors will be strictly monitored, and clarify consequences for noncompliance.

- Prepare youth in advance for meetings and hearings with judges and others. Ask their to reflect on their own behaviors and appearance and their impact on others (i.e. gang symbols or colors). Suggest appropriate alternatives.
- Where appropriate, consider restorative justice and family group conferencing measures that may assist the youth in understanding the impact of their crime and the importance of accepting responsibility for their actions.
- When working with a younger offender, stress the long-term consequences of continued criminal involvement.
- Consider ways, such as role playing, to support and reinforce skills that may prepare the youth to resist negative peer and family influences.
- Never call the youth derogatory names or comment negatively on their appearance or the way they speak (unless they speak disrespectfully). Ignore provocative behavior and dress.
- Juvenile offenders with conduct disorder may have difficulty acknowledging learning problems. Help them examine their learning needs and consider technical, vocational and other alternative education programs.
- Establish a working relationship with the school, family members or surrogate, and other service providers who will be needed to monitor the youth and provide long-term support and guidance.
- Identify activities in which a youth can become involved and build self-esteem.
- Above all, be honest, firm, consistent and assure youth you will "hang in there" with them.

When determining correctional consequences for a youth with conduct disorder, court personnel should consider:

- The age of the youth at onset of conduct disorder-related delinquent behaviors and his or her criminal history;
- The impact of coexisting disorders such as depression and learning disabilities;
- Identifying and involving family members and other significant individuals to support the youth in treatment, correctional and probation programming; and
- Identifying previous interventions used with a youth and determining their effectiveness.

Conduct disorder, particularly when combined with other disabilities, can be extremely challenging for even those who specialize in

this disorder. However, interventions that focus on consistency, learning readiness, educational incentives, and parental or other adult involvement have been shown to increase a youth's competence, commitment to school and trust in working with systems. Additionally, programs that are small; involve family members; regularly gather family and professionals together for planning and consultation; and provide academic, vocational and mental health services have demonstrated success in reducing juvenile delinquency in these youth (August, 1995; Heggenler; forthcoming 1997; Walker, 1991, 1995). Approaches like these, that address the needs of a youth in all of his or her environments, have a greater chance for success than those directed exclusively at a youth's behaviors (Barkley, 1997; Heggenler *et al.*, 1995).

When developing correctional strategies for a youth with conduct disorder, professionals should consider the youth's tendency to engage in more negative behaviors when in contact with more problematic peers in corrections as well as in aftercare settings. Intensive monitoring of the youth may be needed. In fact, Offord (1994) and Walker (1995) propose placing a strong emphasis on approaches that *help a youth resist involvement with delinquent peers as well as attain vocational competencies and academic success.*

Program components and service approaches to consider for youth who have conduct disorder include the following:

- A goal-oriented and supportive educational program based on a youth's strengths and needs, including assessment and special education services;
- Vocational and other functional skills training;
- Social skills, life skills and behavior management training;
- Support, individual and family counseling and education on living with conduct disorder;
- Problem solving, reasoning and conflict resolution skills development;
- Opportunities for a youth to contribute to the community, such as through service projects; and
- Empathy modeling by professionals working with a youth.

If parental supports to the youth are not available or reliable, efforts should be made to link the youth with trained mentors or others familiar with this disability who can provide guidance and encouragement.

Depression

Depression is the most common type of mood or affective disorder. According to the *DSM IV* (1994), mood disorders can be classified into two major types, unipolar depressive disorder (clinical depression) and bipolar disorder (manic depressive disorder).

Unipolar or clinical depression and its signs often go unrecognized. They include:

- Inability to take pleasure in school, social activities, and hobbies;
- Chronic feelings of hopelessness and worthlessness;
- Loss of energy, constant tiredness;
- Lack of appetite, excessive overeating, significant weight gain or loss or failure to make expected weight gain;
- Passive suicide attempts (risk taking behaviors that could end in death not directly by one's own hand);
- A "pulling away" from long-held friends (i.e. social withdrawal);
- Psychomotor agitation or retardation;
- Frequent thoughts of death or suicide or suicide attempts; and
- Physical symptoms such as headaches and stomachaches. (*DSM-IV*, 1994; Garfinkel, 1994; Jensen, 1995; Slaby & Garfinkel, 1995)

It is not unusual for a youth diagnosed with clinical depression to also have attention deficit/ hyperactivity disorder, school refusal, eating disorders, learning disabilities, substance abuse, or conduct disorder.

If a youth has at least four of these symptoms over a period of two weeks or longer, he or she should be assessed by a physician or a mental health professional or both.

It is not unusual for a youth diagnosed with clinical depression to also have attention deficit hyperactivity disorder, school refusal, eating disorders, learning disabilities, substance abuse or conduct disorder. Conversely, a youth with any of these disorders may also be misdiagnosed with depression. The difficulty in assessment arises from the presentation of features common to all of these disorders including symptoms of sadness. For example, a high percentage of youth with conduct disorder also have diagnoses of depression (Milberger *et al.*, 1995). The depression may be more difficult to identify with youth who have aggressive or destructive behaviors. One distinction is that a youth with depression and conduct disorder may more frequently direct those behaviors against

him or herself, while a youth with conduct disorder alone is more likely to direct his or her behaviors outwardly.

There are many ways a youth with depression can express the disorder. These include lying, running away, promiscuity, early sexual activity, substance abuse and overdosing, truancy and gambling, among and combined with others (Garfinkel, 1994). Treatment for most youth with depression includes either counseling or a combination of medication and counseling.

Bipolar Disorder or Manic-Depressive Disorder is a more severe and less common form of depression in youth. It has an earlier onset than depression, beginning at the age of 12 to 14 years. Bipolar disorder is characterized by symptoms that include an alternating pattern of emotional highs (manic episode) and emotional lows (depressive episode). Symptoms can include:

- Psychotic behavior (stemming from thoughts that seem to be out of touch with reality);
- Increased risk for suicidal behaviors;
- Irritability;
- Hyperactivity;
- Uncontrollable spending;
- Rapid talking and body movements;
- Abuse of chemical substances;
- Compulsive and promiscuous sexual behaviors.

(adapted from *DSM IV*, 1994)

A manic phase is always followed by severe clinical depression (Jensen, 1995). Bipolar disorder is treatable with antidepressant medications in combination with counseling.

Working with Youth who have Depression

Behaviors common to a youth with depression may be misinterpreted by those working with him or her as disinterest or insolence. Professionals must be persistent in engaging and monitoring the youth even when he or she shows no signs of cooperation or acknowledgment. A youth with depression, who may also have conduct disorder, Oppositional Defiant Disorder (ODD) or other disruptive behaviors, can express the depression in a variety of problematic behaviors not typically identified as depression. As a result, the depression may be overlooked and remain unaddressed or untreated (Jensen, 1995).

When working with a juvenile offender with depression, professionals need to be aware that arrest and incarceration can result in increased feelings of shame, hopelessness and isolation for an already troubled youth. Furthermore, if a youth was abusing substances at the time of arrest, the resulting aftereffects of withdrawal can intensify the symptoms of depression (Rowan *et al.*, 1995).

Professionals can assist a youth with diagnosed depression by:

1. Consulting with psychiatrists and other mental health professionals treating the youth's depression and integrating treatment strategies, medication information and monitoring into correction and probation plans;
2. Connecting the youth with supportive resources on depression, such as written materials, support groups, etc.;
3. Encouraging the youth to become involved in outlets such as art, drama, music, journaling, physical activities, and recreational programs;
4. Assisting the youth in self-identifying signs of depression and considering options to pursue when depression sets in. If the youth has been involved with substance abuse, help him or her understand the connection between substance abuse and depression;
5. Acknowledging the youth's depression, telling the youth you are open to hearing him or her share her feelings;
6. Immediately notifying a mental health professional if you notice an abrupt or extreme change in the youth's behavior, or if he or she is talking about suicide;
7. Encouraging the youth to persevere, recognize, and celebrate small steps toward progress. Help others who know or work with the youth to do the same; and
8. Contacting state, county or local mental health departments or agencies for assistance, if the youth is not working with a mental health professional.

One survey of youth in correctional facilities showed that both female and male offenders were nearly two-and-one-half times as likely as students in public school to report they had attempted suicide.

Studies of correctional populations have shown that the suicide rate among incarcerated juvenile offenders is significantly higher than that of the general population. One survey of youth in correctional facilities showed that both female and male offenders were nearly two-and-one-half times as likely as students in public school to report they had attempted suicide (Harrison, Fulkerson & Beebe, 1996). It is also known that the suicide rate is higher for youth incarcerated in adult facilities (Lester & Danto, 1993). To respond effectively, professionals need to consider most suicide attempts as failed suicides and not as attention-seeking behavior.

A comprehensive suicide prevention plan in corrections settings includes:

1. A written plan available to all professionals for identifying and responding to youth with suicidal tendencies.
2. Staff training on identifying and responding to risks and indicators of depression.
3. Admission screening for youth with depression.
4. Frequent monitoring of juveniles identified as being at risk for suicide (Parent *et al.*, 1994).

Case Study: Allie

"Allie" is a 16-year-old girl, the oldest of four children. Her parents both work and live in a comfortable suburb. They are committed to their children, their church, and their community.

From an early age, Allie's school experience was frustrating. No matter how hard she tried, she barely passed math and composition. Although her parents were supportive, they agreed with the teachers who said she was not trying hard enough.

When she was in the sixth grade, her parents were told to retain her for a second year as a sixth grader because she wasn't "mature enough" to begin junior high. She was not referred for an evaluation of her learning needs or special education services. By then Allie's academic disparity from her friends was becoming more severe.

Allie began to hang out with other youth who were poor students. They spent much of their time smoking, drinking, shoplifting, and being truant. Her parents tried to be understanding; they met with a counselor and tried to forbid her to spend time with her new friends, but nothing changed.

When Allie and a friend were picked up for shoplifting in a video store, they told the police it was just an initiation into a school sorority, not a real crime. They returned the videos and were banned from returning to the store, but no charges were filed.

Allie's parents did not understand their daughter's change in behavior. In counseling sessions they felt they were being blamed for pressuring her because she wasn't a high achiever. Still, counselors recommended no formal academic or psychological evaluation.

Over the next six months Allie was arrested for curfew violations, shoplifting, and drinking. Community service was imposed but never supervised. Finally, Allie was sentenced to a juvenile facility after being in the getaway car in a robbery with four youth, all older than she was. In the small, structured environment, Allie attended classes and seemed to be doing well, until she abruptiy ran away. She was traced to the emergency room of a hospital after taking an overdose of Tylenol. At that point she was given a complete psychological assessment. It was only then that her learning disability was discovered. She was also pregnant, severely depressed and very frightened.

Allie had a miscarriage halfway through her pregnancy. Following several months of therapy and rest, she was enrolled in a small parochial school. She is now receiving special education services part of the day in a public school setting and is making slow progress with her school and home routine. Her teachers, her counselor and her family all see her as very unlikely to get in trouble with the law again.

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) is a condition that can include unrelenting, intense, and long-lasting feelings of helplessness, numbness, stress and anxiety. It can develop in response to severe, painful experiences in a youth's life. These can include but are not limited to:

- Being a victim of kidnapping, terrorism or hostage situations;
- Sexual, physical or emotional abuse;
- Natural disasters (earthquake, flooding, etc.);
- Being a victim or witness of domestic violence, rape, murder, or suicidal behaviors;
- Being a victim of neighborhood or community violence;
- Being a victim or witness to a severe accident; or
- Life-threatening illness (Pynoos, 1990; *DSM IV*, 1994).

Many juvenile offenders have experienced or witnessed at least one of these violent situations. One study found that 41 percent of youth in the juvenile justice system had PTSD (Nelson, 1996).

The severity of trauma experienced by a youth is influenced by his or her perceptions of, and capacity to recover from, the incident(s) and can vary from youth to youth and incident to incident. A young child's post traumatic stress disorder is typically expressed through anger, fearfulness, distractibility, flashbacks, nightmares, eating problems, physical complaints, intrusive thoughts, jumpiness and psychological isolation. An adolescent with PTSD may have some of these symptoms as well as feelings of guilt and hopelessness. He or she may act out sexually, engage in reckless or violent behaviors, drop out of school, or approach conflict resolution with violence (Pynoos, 1990).

Intensive long-term counseling, often in combination with medication, is the most common treatment. However, even with treatment, a youth with PTSD may continue to experience periodic symptoms for many years.

Working with Youth who have Post Traumatic Stress Disorder

When working with a youth with PTSD, professionals need to consider the following:

- Assist the youth in feeling comfortable while relating traumatizing events, avoid emotional responses and assure the youth that the trauma was not her or his fault.
- Refer the youth to mental health professionals who specialize in PTSD.
- Coordinate the youth's case plans with other agencies working with his or her family or other significant adults.
- Help the youth express feelings through appropriate outlets such as play, art, writing, music, sports and drama.

Working with Youth who have Conduct Disorders, Depression and Post Traumatic Stress Disorder

Coordinated interventions that combine the expertise and resources of the family, school and community are most effective with these youth. Approaches can include:

1. Adapting communication and instruction to the youth's disability;
2. Educating the youth in self-awareness regarding mental health issues;
3. Avoiding confrontational approaches and attempting to involve the youth in examining their behavior and its consequences;
4. Consistent reinforcing of positive behaviors;
5. Teaching conflict resolution skills;
6. Training youth, family members and professionals in conflict resolution, mediation and alternatives to violent behaviors;
7. Social skills training;
8. Involving the youth in prosocial and mentor programs and
9. Parent training and support.

Integrating these approaches in the youth's education programs has significantly reduced school suspensions in some schools (August, 1995; Barkley, 1997; Dikel, 1996).

When appropriate, supportive approaches are formally in place, consistent monitoring, staff guidance, and staff support are needed to ensure that correctional programs can continue to meet the often overwhelming needs of these youth.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) appears at a rate of three to five percent among public school adolescents as compared to 46 percent among youth in the juvenile justice system (*DSM IV*, 1994; Nelson, 1996). This disorder is difficult to define due to the range and various combinations of symptoms that can be present. In addition, ADHD often coexists with other emotional, behavioral, learning, and developmental disabilities, making detection and diagnosis particular challenging. For example, conduct disorders coexist in over 45 percent of youth with ADHD, and learning disabilities coexist in 20 to 80 percent (Barkley, 1997; Cantwell, 1992; D'Alonzo, 1996). Speech and language disorders are also strongly associated with ADHD (Cantwell, 1992).

The *DSM-IV* (1994) describes attention deficit hyperactivity disorder as having three sub-types:

1. Primarily inattentive (ADD, without hyperactivity);
2. Primarily hyperactive; and
3. Combined type.

Most youth with ADHD who are involved in the juvenile justice system fall into the combined type of classification (Barkley, 1995; Bloomquist, 1996). This disability is more prevalent in males than in females, with hyperactivity a more common behavior in males and inattentiveness more common in females (Barkley, 1997; Brier, 1989). In fact, females may be less likely than males to be diagnosed with ADHD because their behaviors tend to be less disruptive (Barkley, 1997; Dikel, 1996). In addition to school failure and poor self-esteem commonly experienced by youth with ADHD, the following characteristics intrinsic to this disability present unique risks for a youth's criminal involvement.

- Impulsivity

Impulsivity is one of the most common behavioral characteristics of ADHD. Impulsivity interferes with the ability of a youth to be reflective. In the need for immediate gratification, a youth with ADHD may act first and think later. This impulsivity may play an important role in risk-taking or criminal behaviors. A youth may not consider beforehand that what he or she is about to do may be illegal. Also, a frequently low tolerance for frustration, linked to the inability to delay gratification, contributes to impulsive choices.

- Irritability and Defiance

Some youth with ADHD may be argumentative, defiant, and challenging; they may have a low tolerance for authority and consistently refuse to comply with parents, teachers, and other authority figures. Diagnoses of Oppositional Defiant Disorder (ODD) and conduct disorder often coexist with ADHD (Satterfield, 1995; Biederman, 1994). As many as 60 percent of youth with ADHD may also have ODD (Barkley, 1997).

- Hyperactivity

Hyperactivity in a youth may be characterized by an inability to be physically still for a sustained period of time and to stay on task in school and in other activities. He or she may appear to be restless and impatient.

- Inattentiveness

A youth may daydream, look or walk around, or even wander out of a room. He or she may appear to be careless in his or her work. Others may assume he or she is lazy or is choosing not to listen or cooperate. A youth may appear to "tune out" or attempt to do too many things at once instead of completing or sustaining focus on one activity. Similarly, a youth may be easily distracted off task by noises or other nearby activities or conversations.

- Disorganization

A youth with ADHD may forget homework, lose papers, and fail to keep track of or to complete assignments. He or she often has difficulty setting priorities, planning, developing organizational strategies independently, or breaking down tasks into manageable portions.

- Delayed Social Skills

More than half of all youth with ADHD are developmentally immature, resulting in delayed social skill acquisition. These youth experience frustration in ongoing social interactions, may have difficulty developing friendships, and may have problems interpreting social cues. (August, 1995; Barkley, 1997)

Working with Youth who have Attention Deficit Hyperactivity Disorder

Stressful situations, such as those experienced by a youth in an interrogation or adjudication process, can exacerbate those behaviors that are common in a youth with ADHD. Increased irritability and defiance in a youth might be expected and may make the processes more challenging for everyone involved. Professionals may con-

sider the following approaches and procedures when working with a youth who has ADHD:

- Collect as much information as possible about the youth before the first meeting.
- Establish some rapport with the youth to reduce the potential for defiance or obstinate behaviors.
- Suspend judgment about a youth and the crime(s) committed or alleged. Perceived blame may provoke negative behaviors. Youth with ADHD often have low self-concept and may tend toward a "self-fulfilling prophecy." That is, their behavior may reflect what they believe others expect of them.
- Anticipate but do not provoke problematic behaviors that may stem from the disability.
- Don't over-represent your power in the justice system. It may initiate a power struggle with the youth; instead, defer to the judge as the final authority.
- Avoid reacting to a youth's "testing" behaviors. Resist interpreting negative behaviors as personal affronts.
- Sit near a door and walk out for a break if the youth's anger or frustration is building up to aggressive or attacking behaviors.
- Avoid lectures. Be clear and honest with the youth about possible options available to him or her. Explain exactly what will happen in the process as well as possible consequences if he or she is not able to cooperate. Follow-through is important.
- If a youth's interactions do not clearly indicate he or she understands what you are communicating, try another way to express it (rephrase, use a pencil and paper, role-play, etc.). For example, a youth's behaviors that may be interpreted as insolence may in fact be a language communication disability coexisting with the ADHD.

Programs that may be more effective with youth with ADHD could include the following components:

1. Realistic, clearly defined behavioral expectations that are frequently repeated and reinforced;
2. Small, structured environments and tasks that adapt to individual learning styles;
3. Cognitive behavior therapies (Bloomquist, 1996);
4. Instruction, including role playing, in developing coping strategies for impulsivity and defiance;
5. Assistance in identifying and integrating strategies that promote organizational skills, task completion and reflective behaviors;

6. Team experiences that promote social integration and modeling of appropriate social skills;
7. Structured group activities that enable youth with differing skills and skill levels to work together toward a common goal;
8. Activities, such as Karate and Tai Kwan Do, that promote concentration, discipline and taking direction from an authority figure (August, 1995);
9. Structured time and focused activities;
10. Medications in combination with other treatment interventions; and
11. Frequent exercise.

Case Study: Jeff

"Jeff" is a 15-year-old boy who was diagnosed with ADHD when he was 8 years old. Although medication helped him to focus and to reduce his impulsive behaviors, Jeff did not like the side effects, so he stopped taking it in junior high. He has been unwilling to work with school counselors to develop strategies that might help him succeed academically.

Jeff's most recent IEP was completed in eighth grade. His mother requested additional testing at that time because of his poor academic performance, but it was not provided. She did not know that she could appeal this decision. He is currently in the tenth grade but at the bottom of his class. His mother suspects he is at least two or three grade levels behind in some subjects. He has failed science and math. His best subjects are art and writing. School officials refer to his high IQ as evidence that he just does not try. He has had continuing difficulties at school with swearing, aggressive behaviors, and truancy.

After repeated truancy and curfew violations, Jeff was sentenced to a small facility in his home state. The program was understaffed; housed primarily older, more violent adolescent offenders; and was run according to a rigid military model.

While at the facility, Jeff was befriended by a 17 year old streetwise offender with a long criminal record. Together, they ran away, stole a car and led police on a high-speed chase. Jeff had no explanation for his involvement in what he knew to be a crime. Like his previous truancy, curfew violations, and school lapses, Jeff just did not "think about" what he was doing.

Because of his attempted escape, Jeff could not return to the same facility. Instead he was sent to an out-of-state facility. Neither of his parents is able to visit Jeff there because of the expense. They rely primarily on infrequent phone calls to stay in contact with their son. It is unclear how much academic instruction he is receiving, since the staff insist they are providing four hours of class time a day, but Jeff tells his parents that all he does is watch television. The staff seems to know nothing about his diagnosis of ADHD.

Jeff's parents were recently advised that he would be released at the end of the school year. With the assistance of an advocate, they have requested his academic records but have not received them. The post-release treatment plan consists of weekly meetings with a probation officer. Despite repeated calls, the probation officer has never been in touch with Jeff, either parent or the school. His school has told Jeff's parents that they will not take him back because they feel it is not an appropriate setting for someone with his record.

Oppositional Defiant Disorder

More than 60 percent of youth with ADHD also have Oppositional Defiant Disorder (ODD) (Barkley, 1997). Typically, ODD, which is common among juvenile offenders, also exists with other disorders which can be addressed in correctional programs through the IEP.

Oppositional Defiant Disorder is expressed as a recurrent pattern of negativistic, defiant, disobedient and hostile behaviors toward authority figures. Those behaviors can include:

- Anger;
- Arguing;
- Defiance and refusal to comply or cooperate;
- Deliberate annoyance; and
- Shunning personal responsibility and blaming others for mistakes and misbehaviors.

These behaviors are similar, but not as severe, as those found in a youth with conduct disorder and generally do not include aggression toward people and animals, destruction of property, repeated theft, or chronic lying and deceit (*DSM-IV*, 1994).

Working with Youth who have Oppositional Defiant Disorder

Severe responses tend to escalate the power struggles provoked by a youth with ODD.

The behaviors of a youth with oppositional defiant disorder, as well as those disabilities that commonly coexist with it, are so challenging and provocative that one might be tempted to respond with severe consequences in order to "teach that kid a lesson" and help him or her to "remember who's in charge." In fact, severe responses can have just the opposite effect on youth with ODD and tend to escalate the power struggles provoked by a youth with this disability. As with many of the approaches suggested for youth with ADHD, approaches to consider for youth with ODD focus away from engaging with their negative behaviors. Avoid emotional interactions. Respond to negative behaviors with clear, direct communication of necessary information, expectations, consequences and goals.

In developing correctional strategies for a youthful offender with oppositional defiant disorder, the following considerations should be included:

- Develop strategies that incorporate consequences as quickly as

possible following unacceptable behavior. Goals should directly address the youth's defiant behaviors.

- Determine whether the youth may have any coexisting diagnoses that need to be addressed. Prior records may be accessed from other systems such as special education, child protection, etc.
- Vocational assessment and job placement goals should be a priority.
- Link youth and family with appropriate resources.
- Identify opportunities for peer learning, team activities, mentor programs, or the arts.
- Develop opportunities for youth to make reparations to the community, if necessary. Identify and arrange for opportunities for community service projects.
- Assist the youth and his or her parents to access information that will provide them with a thorough understanding of the disability and opportunities to learn how to interact with their youth more effectively.
- Provide or arrange for ongoing natural supports and possible in-home counseling for the youth and family.
- Integrate behavior strategies in the school and community so that expectations are consistent.

Learning Disabilities

According to the *DSM-IV* (1994), disorders known as learning disabilities (LD) are:

"... one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, of environmental, cultural or economic disadvantage."

Additionally, the IDEA (1997) specifies that learning disabilities are disorders of one or more basic psychological processes involved in understanding and using written or spoken language and which result in an impaired ability to listen, think, speak, read, spell, or do mathematical calculations. Specific learning disabilities include dyslexia, dysgraphia, dyscalcula, and perceptual disorders.

Learning disabilities include one or more of the following characteristics:

- Difficulties with translating oral language into information, resulting in inappropriate or contradictory responses to instructions, questions, and persons in authority;
- Poorly developed social skills, which result in a lack of understanding of social cues, giving the impression of being discourteous and headstrong (Waldie & Spreen, 1993);
- Poor impulse control;
- Poor choices in peer relationships;
- Risk-taking behaviors;
- Lack of commitment to school; and
- Lack of success in managing the disability (August, 1995; Bailen, Mann & Springer, 1996; *DSM IV*, 1994; Lewcowicz, 1996; Spekman, 1993).

For a youth with learning disabilities, poor academic achievement is often in direct contrast to his or her high intelligence. Due to inconsistent academic achievement, a youth with LD is often de-

scribed as "lazy, unmotivated, inattentive, and not working to potential" (Bailen, Mann & Springer, 1996). Learning disabilities are often referred to as "invisible disabilities" because they are physically unidentifiable.

The prevalence of learning disabilities varies widely from source to source. According to Bailen, Mann & Springer, (1996), 10 to 20 percent of students in regular education have LD. The *DSM-IV* (1994) estimates that approximately five percent of students have been identified as having LD but up to 10 percent may have the disorder and not be diagnosed. Shepherd & Zaremba (1995) cite estimates of LD among students to be anywhere from one through 30 percent. However, in the juvenile justice system, approximately 36 percent of youth have LD (Brier, 1994). If they have a coexisting disorder such as ADHD or conduct disorder, the proportion is even higher.

In one study of juvenile corrections, 50 percent of the youth tested were found to have previously undetected learning disabilities.

Many youth with LD remain unidentified or misdiagnosed (Dikel, 1995). In one study of juvenile corrections, 50 percent of the youth tested were found to have previously undetected LD (LD Association Fast Facts #13, 1996).

Youth with learning disabilities are twice as likely to commit a delinquent offense than their non-learning disabled peers (Brier, 1989). Those who have LD coexisting with ADHD are at highest risk for offending due to their more disruptive and noncompliant behavior (Brier, 1994). Furthermore, language-based LD impacts both comprehension and judgment with more profound verbal deficits often resulting in more aggressive behaviors. This may result in greater difficulties with problem-solving, anticipating consequences and moral reasoning (Brier, 1989). Learning disabilities also often coexist with other behavioral disorders such as ADHD and ODD. The LD may go undetected as behavioral characteristics may interfere with its diagnosis.

If a youth cannot understand or master a particular learning task, he or she may lose interest in the subjects he or she is failing. He or she may not complete assignments or may seem to ignore deadlines. It is not unusual for a youth with learning disabilities to fail some subjects and excel at others. When LD is not identified and a youth does well in some subjects and poorly in others, parents and professionals may believe the failure is intentional or the result of laziness or low intelligence. Over time, a youth with LD may integrate these explanations, compounding their propensity towards low self-esteem, depression, truancy and dropping out of school. Furthermore, if one focuses solely on a youth's behaviors or failures, the learning disabilities may be overlooked.

Among students with identified learning disabilities, 35 percent drop out of high school, a rate twice that of peers without disabilities (LDA, 1996). School dropout is a significant risk factor in later juvenile delinquency. Among youth with LD, 62 percent of those who dropped out of school were arrested within three to five years; among those who did graduate, the arrest rate was 15 percent (Wagner, 1992).

The persistent failure can lead to a lack of confidence and self-esteem as well as behavioral problems. In order to "fit in" with their peer group, a youth with LD may more readily yield to peer pressure, even when aware that the behavior is wrong. Language deficits have been linked to inadequate problem-solving skills, diminished moral reasoning and lack of understanding of consequences in these youth (Brier, 1989). Overall, youth with LD experience low self-esteem, have difficulty anticipating consequences for their actions, are prone to suggestibility, are less flexible and are at a higher risk for acting out behaviors (Waldie & Spreen, 1993).

Working with Youth who have Learning Disabilities

If a youth is a first time offender involved with juvenile court, a screening for learning disabilities would ensure the youth is accorded appropriate accommodations for participating in the justice process and also has access to disability-specific correctional programming.

Those working with a youth with LD can assist the youth in organizing his or her thoughts, perhaps by tape recording or having him or her write down a chronology of events and review it.

The impact of LD on understanding spoken language is of particular concern for a youth accused of committing a crime. For example, a youth with LD may not adequately understand the concept of Miranda rights. The Miranda rights are a list of constitutional rights, including the right to be represented by an attorney, that is read to persons at the time they are arrested. Studies show that a majority of individuals do not understand what it means to "waive your rights" when the Miranda warning is read, even if the statement is adapted into elementary language (Shepherd & Zaremba, 1995).

In addition, a youth with learning disabilities may not be able to relate his or her story logically, consistently answer questions correctly, or follow instructions. These inconsistencies may result in police officers, juvenile intake personnel, attorneys and other court personnel believing the youth is being uncooperative or is lying (LDA, 1996). Those working with a youth with LD can assist the youth in organizing his or her thoughts, perhaps by tape recording or having him or her write down a chronology of events and review it.

Most youth with learning disabilities overcome their challenges and become successful, personally and professionally. To promote success in youth with LD, professionals who work with them need to consider the following:

- Prescreening youth for LD assessments early in justice processes. Many youth with LD are misdiagnosed or not diagnosed;
- Determining the need for vocational, technical and functional skills assessment;
- Developing a comprehensive and appropriate special education, vocational and counseling program, if necessary (Spekman, 1993);
- Making referrals to agencies serving youth with LD and their families;
- Assisting a youth in self-understanding and acceptance of their disability, how to be proactive, how to set realistic goals, and how to persevere in getting his or her needs met and in reaching goals (Spekman, 1993); and
- Mentoring relationships that are supportive, directive and understanding of the LD.

Developmental Disabilities

The category of developmental disabilities (DD) is comprised of severe, chronic disabilities attributed to mental or physical impairments or combinations of mental and physical impairments with onset before age 22. These disabilities are likely to continue indefinitely and result in substantial functional limitations in three or more areas of major life activity. They also are likely to result in the need for a combination of special, interdisciplinary or generic care, treatment, or other services which are lifelong or extended and are individually planned and coordinated (IDEA, 1997).

Mental retardation and **autism** are two examples of developmental disabilities present among youth in the juvenile justice system. Some youth with mental retardation may also have ADHD or conduct disorder. Youth with autism may also exhibit impulsivity, aggressiveness, short attention span, and obsessional behaviors. (Conley, *et al.*, 1992; *DSM-IV*, 1994; Noble & Conley, 1992)

It is difficult to determine how many persons with developmental disabilities enter the justice system. The prevalence of mental retardation in the prison population is 12.6 percent (Leone, 1991). The presence of a developmental disability may not be detected if aggressive behaviors, mental illness, substance abuse, seizure disorders or speech, hearing or communication difficulties are more apparent; individuals with DD may thus not be identified by law enforcement officers or other professionals as having a disability (McGee & Menolascino, 1992). Furthermore, adolescents may be unlikely or unwilling to acknowledge their disability.

Certain characteristics of developmental disabilities may lead a youth to confess to a crime because he or she wants to please adults and believes that is what the authorities want to hear. Also, youth with DD are more likely to be convicted of the offense rather than of a reduced charge (Lustig, 1995)

Characteristics of developmental disabilities in a suspected juvenile offender include:

- Smiling inappropriately during interrogation;
- An inability to understand or answer questions, so responses do not seem to make sense;
- Difficulty in being understood because of extremely limited ver-

bal ability or a speech impairment;

- Overly eager to please authorities with responses, even when those responses sound unreasonable;
- Difficulty with simple tasks such as telling time, reading and writing or using the telephone or a telephone book.

(Adapted from The Arc, from *Defendants, Victims and Witnesses with Mental Retardation.*)

Mental Retardation

The most common developmental disability, mental retardation (MR), affects three percent of the general population (NICHCY, 1991). A 1990 analysis estimated that 12.6 percent of incarcerated youth qualified for a diagnosis of MR (Leone *et al.*, 1991).

A youth with mental retardation is significantly below average in intellectual functioning and has coexisting limitations in two or more of these skill areas:

- Communication;
- Self-care;
- Home living;
- Social skills;
- Community use;
- Self-direction;
- Personal health and safety; and
- Academics, leisure and employment.

Three unique risks for youth with mental retardation to become involved in unlawful behaviors include:

- Peer influence. A youth with MR may be more easily influenced, and therefore more vulnerable, to being exploited by an experienced criminal. Typically, they are an accomplice to a crime rather than the initiator.
- Low self-esteem. The involvement of a youth with MR in a crime committed with others may stem from the youth's need to feel personal connections with others, especially those without apparent disabilities. The youth may be seeking reinforcement of his or her need to be seen "like everyone else," rather than as a person with a disability.
- Lack of a comprehensive understanding of illegal activities and their subsequent consequences (Wood & White, 1992).

Most offenses committed by a youth with DD tend to be nonviolent or are misdemeanors (Reynolds, 1995). Serious offenders with DD are often immature, impulsive and have severely impaired judgment and ability to manage their anger (Jefferson, 1995). They are vulnerable to victimization by people close to them through abuse or manipulation. Offenders with DD who commit more serious and aggressive crimes are often dually-diagnosed with mental health disorders (Brady & Jefferson, 1996).

Because of their typically low self-esteem, youth with DD may be drawn to anyone who will "befriend" them. The "friendships" and excitement of risky behaviors are tempting for a vulnerable, eager-to-please youth. Similarly, youth with DD may be recruited by more experienced criminals, who recognize that the person most likely to be caught in a crime is the more vulnerable "accomplice" rather than themselves. They may assume that youth with DD will not be credible witnesses and may be unable to convincingly identify a ringleader.

Offenders with DD who commit more serious and aggressive crimes are often dually-diagnosed with mental health disorders.

Autism

Autism may be manifested in a number of behaviors and with varying degrees of severity. A youth with autism often has difficulty with expressive and nonverbal language, comprehension skills, language processing, and social and interactive skills. He or she may have difficulty making eye contact or expressing emotions in a typical manner; may exhibit repetitive behaviors, such as rocking, hand wringing or pacing; and may not be able to focus well on one task (*DSM-IV*, 1994).

According to the *DSM IV* (1994):
"Essential features (of autistic disorder) include... impaired development in social interaction and communication and a markedly restricted repertoire of activities and interests. There may be marked impairment in the use of nonverbal behaviors (facial expression, eye to eye gaze, body postures and gestures) to regulate social interaction and communication. There may be... monotonous, impaired or repetitive speech, or a disturbance in the comprehension of speech. Children with autistic disorder may have short attention span, impulsivity, aggressiveness, and self-injurious behaviors."

The IDEA (1997) defines autism as a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects educational performance.

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To someone unfamiliar with these behaviors, a youth with autism may appear to be lacking in remorse or to be indifferent to the crime he or she is accused of committing. A youth's lack of typical expressiveness may suggest a guilty demeanor to some, when in fact they may be anxious or emotionally disconnected from the events going on around them.

Working with Youth who have Developmental Disabilities

If a youth with developmental disabilities becomes involved in the justice system, it is important that someone who knows the youth or is knowledgeable about DD is present. However, efforts to identify a youth with DD in the justice system are not generally reliable or systematic (Brier, 1989). In fact, at the earliest stages of the criminal justice process, it is highly unlikely a youth will be properly identified as having DD (Conley *et al.*, 1992).

Assumptions may be made that the youth understands the charges or understands the implications of confessing to a crime, or that his or her behavior indicates a lack of remorse.

Questions regarding accurate identification of a developmental disability are critical because they have implications for the individual's competence to understand criminal charges, participate in his or her own defense, and stand trial or have his or her sentence appealed. Assumptions may be made that he or she understands the charges or understands the implications of confessing to a crime, or that his or her behavior indicates a lack of remorse. The competency standard relates to whether an individual understands the charges and can participate in his or her own defense. These assumptions can affect any decisions regarding determination of the youth's competency to stand trial.

It is only recently that educators, parents and health and social service professionals have focused on the need for youth with developmental disabilities to learn about risky behaviors and assertiveness skills. Correctional goals should include opportunities for consistent, repeated instruction and role play exercises regarding vulnerability, illegal behaviors and risky relationships.

In *Residential Facilities for Juvenile Offenders* (1995), Minnesota's Legislative Auditor's evaluation acknowledges the lack of specialized services for offenders with developmental disabilities, as well as for those offenders with both DD and aggressive sexual behaviors. In most correctional facilities, persons with mental retardation are expected to follow the same rules and regulations as others. Their inability to comply because of cognitive differences makes it more challenging for them to earn privileges and, ultimately, an early parole.

Because of their need to be accepted, youth with developmental disabilities may be likely to integrate the negative values in prison culture (Santamour, 1986). Furthermore, they are uniquely vulnerable to victimization and sexual abuse within many correctional settings (Pranis, 1991; Santamour, 1986). Because of their cognitive differences, they may rely on aggressive behavior as a means of self-defense or may be unable to meet the conditions for early parole (Smith, 1990). In addition, they have more difficulty participating in the development of a release plan, and often serve longer sentences than other offenders for the same offense (Lustig, 1995).

Conversely, professionals are concerned with the apparent lack of meaningful correctional options available when serious criminal cases against people with developmental disabilities are dropped due to their inability to understand the charges or to participate in their own defense. Often these cases involve assaultive or violent behaviors. The absence of any consequences may be disappointing for the victim as well as ineffective for the potential rehabilitation of the offender.

Post-release programs and services designed specifically for youth with DD are rare. Once released, youth with developmental disabilities have few options in appropriate probation programs, such as group homes, therapeutic foster care, or mental health and substance abuse programs. They often have limited work skills, and they may have developed or intensified antisocial behaviors while in prison. Without appropriate activities, employment and a transition plan back into the community, the likelihood that they will reoffend is high (Leone, 1990). Like all young offenders, youth with DD need ongoing supports in school, in the community and within the family to effectively reinforce acceptable behaviors.

A standard series of questions, considered at the time of arrest, interrogation or sentencing, will help ensure that a youth with developmental disabilities is identified, afforded due process, and that his or her disability addressed in disposition. These questions include:

1. Should a disability professional be consulted?
2. If a youth has cognitive or communication impairments or both, has someone who knows his or her communication patterns been consulted?
3. Does the youth understand the relationship between the behaviors that led to the arrest and the consequences considered or imposed?
4. Are there programs better able to accommodate the youth's disability and possible vulnerability?

5. Is the youth currently receiving special education and mental health services? Does he or she have an IEP? If not, is an evaluation or assessment needed?
6. Are the proposed consequences likely to be meaningful to the youth, considering his or her disability?

Correctional and probation programming for youth with developmental disabilities should focus on:

1. Training and employment opportunities;
2. Development of functional, cognitive and social assets;
3. Self-awareness;
4. Healthy sexuality;
5. Identifying vulnerabilities and learning self-protection strategies;
6. Self-image and self-esteem;
7. Assisted living residences and/or independent living skills and
8. Promotion of typical developmental milestones.

Probation services for a youth with developmental disabilities should emphasize close supervision and attainment of functional and job skills. Substance abuse and mental health treatment programs, if needed, should be adapted to the disability of the youth. Also, correctional alternatives to incarceration should be considered for a youth with DD who has aggressive behaviors. Options include programs that involve the family, group homes, therapeutic foster placements and separate programs for persons with developmental disabilities within correctional facilities. All correctional program staff need adequate training on working with youth who have DD. Overall, a youth with DD needs a combination of services or supports that is lifelong and individually planned and coordinated (Laski, 1992; Morton, *et al.*, 1986; Wood & White, 1992).

Communication Difficulties Confronted by Individuals with Mental Retardation

People with mental retardation face a number of communication difficulties, all of which negatively affect their rights in the judicial process. The following is a list of some of these difficulties:

A. An Eagerness to Please- Individuals with mental retardation do not communicate on an "equal footing." They are eager to please others and are often unusually accommodating, especially to those persons they view as being in positions of authority (police, attorneys, judges).

B. Concrete Thinking Patterns- Individuals with mental retardation are unable to engage in abstract thinking. They think only concretely. For example: When asked if he wishes to waive his rights to have an attorney present before talking to police, an individual with mental retardation may be concretely focused on waving his right hand as opposed to waving his left hand.

C. Communication Through Mimicking- Individuals with mental retardation often learn to do things the "right" way by copying others. They learn to communicate by affirming the choice that is suggested last.

D. Communication Through Protectors- Individuals with mental retardation learn to communicate through the "voice" of a protector. In the hands of the wrong "protector," instead of friendship there is domination, and the person with retardation can engage in crime at another's behest.

E. Communication Through Bluffing Greater Understanding- Individuals with mental retardation often seek to mask their disability, trying to pass for so-called "normal."

F. Communication Through a Pleasant Facade- Individuals with mental retardation learn that smiling is one way to gain approval or to have their needs met. The problem that arises is that they do not know when their smiling is inappropriate.

G. Problems with Receptive and Expressive Language- The most common communication difficulty is the problem that individuals with mental retardation have in expressing themselves, usually because of intellectual deficits (illiteracy). They may not be receptive to the ordinary flow of spoken language, requiring that they be spoken to more slowly and clearly.

H. Limited Memory/Impaired Recall- Even when individuals with mental retardation can verbalize effectively, their ability to remember and recall events may be impaired. This is particularly true of events that the individual has not deemed to be important.

I. Impulsivity/Short-Attention Span- Individuals with mental retardation are often described as having poor impulse control. This characteristic is related to difficulties with attention span and focus.

Questions to Ask If You Suspect a Defendant Has Mental Retardation

1. Was the individual classified in school for special education?
2. Has the individual ever held a steady job?
3. Does the individual have a driver's license?
4. How does the individual support himself?
5. Does the individual receive any financial assistance such as Supplemental Security Income (SSI)?
6. Does the individual appear to understand the questions being asked?
7. Does the individual respond to questions without unnecessary delay?
8. Does the individual have an eagerness to please others?
9. Can the individual explain his or her actions in his or her own words?

"Communication Difficulties..." and "Questions If You Suspect..." are from *Defendants with Mental Retardation: A Guide for Attorneys,* produced by the Developmentally Disabled Offenders Program, The Arc of New Jersey, 1996. Adapted with permission from Suzanne Lustig, Director of the Developmentally Disabled Offenders Program.

Case Study: Ben

"Ben" is a 15-year-old African American with mental retardation who lives with his mother in an inner city neighborhood. Ben's mother, Jessie, also has mental retardation as well as depression. Jessie has worked steadily for eight years and is very devoted to her son.

Ben fits none of the stereotypes that exist about mental retardation. He doesn't look "different," he likes sports and knows the names of his favorite players, and he always has a few girlfriends. Kids at school know that Ben is "slow." They don't hang out with him, but they're not deliberately unkind to him. Until he got into trouble with the law, Ben would have been described as "gentle," an unlikely person to act violently.

Someone approached Ben in the neighborhood to have some fun together, maybe smoke some pot and hang out. It was an irresistible invitation for him, since this was someone older and known as a "cool" guy. So they shared a joint and then went out to find a dealer with more drugs to sell. Ben was there when his "friend" got into a car driven by someone else, traded some drugs and money, exchanged some words with the driver, and shot him. Ben didn't know the gun was real. In fact, at first he thought it was a joke. He knew he should not have had marijuana, but he couldn't believe that someone would actually shoot another person for apparently no reason.

When the police brought him into the precinct for questioning, Ben giggled, grinned, and paced the room. To the police, Ben didn't appear to have a conscience. "He appears to have no remorse," stated the police report. There was no attorney present at the police interview. The police did not know that Ben has an IQ of 65 or that, although he had the keys in his pocket, he did not know how to start the car. Ben was booked as an accessory in the murder as well as for possession of drugs.

Fortunately, Ben was assigned a knowledgeable public defender that quickly raised pertinent questions regarding Ben's competency. She argued successfully for a reduced charge. Ben was sent to a correctional facility for six months, where he was continually harassed by other boys for being "slow." Much of his time was spent watching television. Ben's county social worker describes him now as truant, aggressive, and highly vulnerable to being exploited again.

Chapter II

Entitlements for Youth with Disabilities in the Justice System: Individuals with Disabilities Education Act (IDEA)

The Individuals with Disabilities Education Act (IDEA) is a federal special education law. The law guarantees youth with disabilities through the age of 21 who need special education and related services a free, appropriate public education (FAPE), and provides them and their parents with specific due process rights. Special education and related services must be provided to eligible youth regardless of whether they have been referred to a correctional placement. FAPE must be in accordance with state standards and must include an appropriate elementary or secondary education curriculum.

An Individualized Educational Program (IEP), which is based on an evaluation of the youth's educational needs, describes the services that will be provided and lists specific learning goals and objectives that are considered reasonable to achieve during a one-year period. The IEP is developed by a team that includes educators, providers, and the youth and his or her parent(s).

Under the 1997 Reauthorization of the Individuals with Disabilities Education Act, states may transfer the responsibility for educating juveniles convicted as adults and placed in adult prisons from state and local education agencies to any other public agencies deemed appropriate by the Governor of the state. The new law also authorizes agencies to modify the Individualized Education Program for genuine security reasons or compelling penological reasons. This authorization is very limited and must be directed only to the most serious concerns for which no other alternatives can be found.

For those educational programs run by the Department of Corrections (DOC) in Minnesota, responsibility for educational services for the term of the sentence transfers to the Department of Corrections. If the DOC does not run an educational program in a par-

ticular juvenile facility, these services will be provided by the school district in which the facility is located.

While other states may have different laws governing services to specific populations of youth, in any instance the provision of special education and related services to eligible children with disabilities requires the full implementation of all substantive and procedural requirements set forth in IDEA.

Some facilities have standard educational and vocational training programs for youth. Although these regular education services are offered quite widely for some youth, contrary to state and federal law they may not necessarily be consistent with standards of the state education agency (SEA). Frequently special education and related services are not provided as required by law. Psychological and mental health services are often contracted out on an "as needed" basis to psychiatrists or psychologists, instead of being provided as part of the "appropriate education" consistent with the youth's IEP.

As defined in IDEA the term "special education" means "specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability." Under this law, youth who have a disability and who meet IDEA criteria for special education services are entitled to receive a free, appropriate public education wherever they live or go to school. This includes the right to appropriate educational services in facilities such as schools, alternative learning centers, treatment facilities, group homes, camps and correctional settings.

Related services include transportation and such developmental, corrective, and other supportive services as may be required to assist a child with a disability to benefit from special education. Specific related services include:

- Speech-language pathology and audiology
- Psychological services
- Physical and occupational therapy
- Recreation, including therapeutic recreation
- Social work services
- Counseling services, including rehabilitation counseling
- Orientation and mobility services
- Medical services, to the extent that medical services are used for diagnostic and evaluation purposes only
- Early identification and assessment.

Mental health services, such as individual or group counseling provided by a school psychologist, social worker, or counselor, are "related services" for students with disabilities when they need such services to benefit from their special education programs. Under Section 504 of the Rehabilitation Act (see page 48), a youth with a disability may also be entitled to receive related services, even if they are not "necessary to benefit from special education." Courts have interpreted the concept of education to be very broad and to include self-help skills. The definition of education under IDEA encompasses more than academics. It includes "specialized instruction and related services necessary to enable a child with disabilities to benefit from the educational program." Yet, related services are frequently omitted from IEP's at the local school district level. Consequently, a youth with mental health needs may move into a correctional setting with a special education program plan that does not adequately reflect his or her learning needs. Even in cases where a youth does have an appropriate Individualized Educational Program plan when he or she enters a correctional facility, the Office of Juvenile Justice and Delinquency Prevention has found that most correctional facilities do not provide necessary health and mental health services. This is in direct violation of IDEA, Section 504 and state law.

Who is responsible for ensuring that youth who are in corrections facilities and who were receiving special education services prior to the placement continue to receive them?

The Local Education Agency (LEA) in which the correction facility is located or other agency designated by the State Education Agency is responsible for carrying out the special education programs of juveniles who are incarcerated. In Minnesota, for example, the Department of Corrections has been designated as the LEA (school district) responsible for the provision of special education and related services when youth are placed in correctional settings that run their own educational programs. Special education services may not be discontinued simply because a youth has been placed in a correctional setting.

Who provides special education services?

It is important that providers of special education services be appropriately licensed and that they have the specialized knowledge needed to provide services. They include:

- Special education teachers
- Psychologists

- Social workers
- Psychiatrists or licensed mental health professionals
- Other appropriately licensed personnel

What are some examples of special education services?

- Individualized academic instruction
- Anger management and conflict resolution skills
- Work readiness skills or work experience training
- Independent living skills training
- Any other area where there is a need for specialized instruction

School districts (including the Department of Corrections, when it operates as a school district), are responsible for conducting a *multidisciplinary evaluation* to determine whether a young person is in need of special education and related services as a result of having a disability. If a youth who has been referred to a juvenile facility is not receiving special education programming and related services, but is exhibiting behavior that suggests that he or she may have a disability that requires these services, an evaluation should be initiated as soon as possible. However, there is an exception to this requirement. The 1997 IDEA does not require states to evaluate or to provide special education and related services to youth aged 18-21 who are convicted as adults and incarcerated in adult prisons and who were not previously identified as having a disability or were not receiving services through an IEP immediately prior to their incarceration. States may elect not to serve this group of youth if that decision is consistent with state laws.

Who requests an evaluation?

School districts and other responsible agencies have an affirmative obligation under the child-find responsibility of IDEA to locate, identify, and assess children suspected of having a disability and needing special education services. If parents, attorneys, judges, or other involved persons believe that because of behaviors a youth may be in need of special education and related services, the first step is to request a comprehensive multidisciplinary evaluation. Many correctional facilities will arrange with their local school district or the district in which the youth's parents reside to conduct this evaluation. Reevaluations may be conducted whenever conditions warrant, or at the request of a parent or teacher, but must be completed at a minimum once every three years.

Does a parent need to give permission before an evaluation takes place?

An educational evaluation or reevaluation of a young person under the age of 18 requires that a parent, surrogate parent or legal guardian provide written consent before the evaluation takes place. Such consent must be "informed," which means that the person granting permission for assessment should understand why the assessment is needed and what specific tests are being proposed. If parents have received a request from a public agency to conduct a reevaluation, and do not respond within the timeline (usually ten days), it can be considered as permission to proceed with the reevaluation.

Who should conduct an evaluation or assessment?

The evaluation must be completed by a multidisciplinary team, which may include a psychologist, teacher, therapist, educational diagnostician, or other person. The evaluation cannot use a single test or tool to determine the needs of a youth with a disability. Evaluation tools must be selected to ensure that they will not discriminate based on a youth's disability or racial, cultural, or linguistic background.

What happens if a youth is a "ward of the state" or if the parents are unknown or cannot be located?

In this instance, a *surrogate parent* must be appointed and trained by the school district to serve in the role of parent specifically for special education planning purposes. Youth over the age of 18 may assume the role of "parent" for the purpose of granting consent for their own evaluation. This is not intended, however, to deny parents their participatory rights in their child's educational planning.

Who pays for the evaluation?

The evaluation must be provided at no cost to the family, even when components of the evaluation include medical or mental health examinations. This evaluation is key to determining whether a youth needs special education services or accommodations in his or her learning program.

How is the information from the evaluation used?

If the evaluation shows that a youth is eligible for special education services, the results will be used to develop an Individualized Education Program (IEP) plan, the document which outlines the special

education and related services that must be provided in order to address the youth's individual needs.

An IEP is a written plan that is designed to meet the specific educational needs of a child or adolescent, based on an evaluation of the youth's needs. The IEP includes:

- present levels of educational performance statements
- measurable goals, and benchmarks or short-term objectives
- special education and related services and supplementary aids and services, and program modifications, or support for school personnel
- the amount of time, if any, student will **not** participate with nondisabled children in the regular class and activities
- individual modifications in state or districtwide assessments for the student to participate in the assessment, or why the assessment is not appropriate and how the child will be assessed
- the projected date for the beginning of services and modifications, and frequency, location, and duration of services and modifications
- beginning at age 14, transition service needs of the child, and, beginning at age 16 (or earlier), transition services; at least one year before a child reaches the age of majority, a statement that the child has been informed of his or her rights that will transfer to the child
- how progress towards the annual goals will be measured, and how the child's parents will be regularly informed of progress

Who is involved in writing the IEP?

An IEP is developed by a team of persons, including parents, the youth's teacher(s), the youth (when appropriate), a representative of the school district, and other individuals with information about the needs of the youth. Both the child and parent(s) should be involved in developing the goals and objectives. Any young person over the age of eighteen may legally act as his or her own "parent" in developing the IEP and agreeing or disagreeing with the proposed services.

What if the parent doesn't agree with what is written in the IEP?

Federal law guarantees parents the right to participate in the development of their child's IEP and to disagree *in writing* with any program or services they do not believe meets their child's needs. Disagreements may be resolved in one of several ways:

1. **Mediation**: an informal conference with a trained objective third party who attempts to help resolve the concerns between parents and the school district. The mediator is not a decision-maker. Although mediation is not required, states may enact laws which requires a parent who refuses to engage in mediation to meet with an outside person who can explain the benefits of this form of dispute resolution.
2. **Due Process Hearing**: A formal dispute resolution process established in the IDEA. Usually a due process hearing is requested when less formal methods have not been successful. Either a parent or a school district may request a due process hearing. An impartial due process hearing officer serves as a third party to hear both sides of the disagreement and issue a decision, which is binding upon both parties. If either parents or schools are not satisfied with the decision of the Hearing Officer, the decision may be appealed. In Minnesota, appeals are directed to the State Commissioner of Education.
3. **Complaint**: A complaint is an allegation that a school district is not in compliance with established special education law. Complaints may be submitted to the State Department of Education and will be investigated by a complaint officer. A corrective order will be issued if the complaint officer substantiates the issues stated in the complaint.

Can the correctional facility use the IEP that is forwarded with the youth's records?

Yes. If a young person already has a current IEP upon entering a correctional facility, an IEP team should be convened *as soon as possible* to determine what modifications, if any, will be needed to reflect the change of placement from a school-based to a correctional program. A discussion about whether additional evaluation is needed should also take place at this meeting.

Is the correctional facility "automatically" provided with information by the school district about special education records or an IEP when a youth enters a facility?

Not always. One of the difficulties in providing services has been that the correctional facility may not have adequate information about the needs of youth entering a correctional setting. If they are asked, some youth will not necessarily acknowledge that they have received special education services. It is important that a parent, case manager, attorney, probation officer, previous special education teacher, or any other professional familiar with the youth make

special education information available in writing to the director of the correctional facility as soon as possible following the placement. However, it is the legal responsibility of the agency providing educational programming to request a transfer of the youth's educational records from the most current school setting, so that services can continue in the new setting. The state Department of Education must assure that procedures and policies are in place to ensure the provision of a free, appropriate public education (FAPE) to all eligible students regardless of where they receive educational services.

What happens if a youth has dropped out of school?

If a youth was receiving special education services before dropping out of school, this information is valuable to the correctional facility. A review of the student's records and a discussion of present problems should help the team decide whether the assessment remains valid, whether a new assessment is needed and whether the student has a current IEP. Truancy and dropout are both closely tied to juvenile criminal behavior and to chronic school problems. By addressing student needs through special education in a structured setting, it may be possible for many youth to acquire needed skills.

What if the information in the IEP is outdated?

Some youth may have Individualized Educational Programs that are outdated or inappropriate to their current needs. If families move frequently or if youth are placed out of their family home, it is possible that copies of the IEP and other valuable educational records may be misplaced during the transfers. The needs that were documented on a youth's IEP may not be addressed or reviewed at the time of placement. A request for school records should be initiated as soon as possible for the youth who does not have these records at the time of placement. State and public agencies have an obligation to provide FAPE to identified youth that cannot be dismissed simply because records are missing. At times, this may mean that the agency and family need to agree on an "interim" plan while records are being located or the youth is being reevaluated.

Is a youth entitled to services while he or she awaits case disposition and placement in a correctional setting?

The state must meet its obligation under IDEA by implementing the IEP from the previous school district. If that is not possible for compelling security or penological reasons, then services that ap-

proximate the old IEP as closely as possible must be provided. An IEP meeting must be scheduled as soon as possible to discuss potential changes with parents.

Section 504 of the Rehabilitation Act of 1973 is a broader federal law than IDEA. It applies to any agency under which a youth might receive services, not just schools. Section 504 states that:

> "no qualified person with a disability shall, on the basis of disability, be excluded participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives benefits from federal financial assistance" (34 CFR 104.3{a}).

How does a youth qualify for the protections offered under Section 504?

A "qualified individual with a disability" under Section 504 is one who:

- has a physical or mental impairment which substantially limits one or more major life activities (caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working)
- has a record of such an impairment

or

- is regarded as having such impairment.

Can a youth receive accommodations under Section 504 without qualifying for special education services under IDEA?

Yes. After an assessment has been completed to determine the impact of the disability on learning, he or she may be eligible under Section 504 for accommodations in the regular education setting, or for placement in a setting that meets his or her needs. A Section 504 team should be convened for students with disabilities who do not meet the special education criteria for services, but whose disabilities significantly affect their education, to determine the necessary modifications or accommodations the youth will need to be successful.

A Section 504 plan or accommodation plan is of particular importance for youth who have diagnoses such as learning disabilities, Attention Deficit Hyperactivity Disorder (ADHD), depression or other disabilities, but whose problems may not be severe enough to require special education services. Related services, such as mental health counseling, may be required under a Section 504 plan, even

if the youth is not eligible for "special education and related services" under IDEA. A school district is responsible for implementing any accommodations the team determines necessary.

Both the IEP and the Section 504 plan specify the instruction and related services that a youth is to receive, regardless of where education is provided.

When should planning begin to prepare a youth for his or her return from a correctional setting back to the home school district?

Transition planning between the correctional facility and the home school district should begin well in advance of the youth's release to ensure there is no break in educational programming.

What kind of planning is recommended for the youth in his or her return to the community?

Transition planning should become part of the youth's IEP. Assuming that courts felt the need to remove a youth from society to an institutional setting, the goal should at all times be to reintegrate success fully into the community. For youth, "community" includes the opportunity to be with peers of similar age.

It is important to gather a record of the credits earned in the correctional setting so that the youth does not have to repeat classes that have already been completed. There should be some discussion and clear guidelines about what are reasonable expectations for adhering to normal school policies. In residential settings, the rules are usually clear and consistent. In schools, however, the variety of learning environments and differing adult expectations can result in an enormous amount of stress on youth with disabilities. It is important that in developing a new IEP for return to the school setting, there is an agreement among the youth, the parent, and possibly an advocate regarding school expectations and needed modifications, so that the student will have success in the school environment.

Discipline in the Schools

Schools frequently have one disciplinary standard for all students, regardless of a youth's limitations or circumstances surrounding the occurrence of a behavior. When a youth is unable to conform

his or her behavior to the discipline standards established for all students in the school, the IEP team (which should include representation from the most recent correctional setting) should meet to develop an individualized behavior support plan as part of the IEP or Section 504 plan. It is important to recognize that youth with disabilities have certain substantive and procedural safeguards under IDEA and Section 504, including the right to FAPE and the right not to be punished for behaviors related to their disabilities.

What are some examples of individualized behavior support strategies?

The emphasis should be on using appropriate interventions that support behavioral development and ensure that the consequences for unacceptable behavior are designed to teach the youth alternatives to that behavior. The simplistic-sounding "catch them being good" phrase is actually an excellent intervention strategy for reinforcing appropriate alternative behaviors through recognizing and rewarding acceptable behaviors. While punishment may temporarily stop unacceptable behaviors, it does not teach alternatives to the behaviors of concern. For students who have aggressive or otherwise unacceptable behaviors, a free and appropriate public education includes the duty to address the cause of their inappropriate behaviors. A number of court cases have discussed the failure to provide FAPE to address cause. Building self-esteem and self-confidence means providing high quality instruction with support services designed to address other needs that impede the ability to learn and reach standards expected for all other students.

What if the school is not willing to modify its response to the student's behaviors?

Schools are required to modify or amend where necessary any part of the school discipline plan to accommodate a student's disability. Under Section 504 of the Rehabilitation Act, a refusal may constitute discrimination on the basis of disability. A complaint to the federal Office for Civil Rights (OCR), alleging that the educational program has discriminated against a student on the basis of disability, is the avenue for addressing a refusal to make necessary accommodations. Or a due process complaint may be made under IDEA for failure to address the educational needs of the student that are interfering with the right to FAPE.

Education under IDEA and Section 504 has been broadly construed by courts to encompass a wide range of services. New 1997 amendments require the IEP team to address behavioral issues, including

a functional assessment to help determine why the behavior occurs. A youth's IEP should include specific strategies to teach the youth alternatives to inappropriate behaviors.

What happens if the rules imposed by the school are impossible to comply with because of a youth's disability?

If the IEP team agrees that a student is unlikely to be able to adhere to a rule or to learn from the standard consequences of not following a specific rule due to a disability, it will be important to develop alternative consequences for the noncompliant behavior. The consequences for noncompliance with any rule, combined with appropriate instruction, should serve to teach a youth necessary behavioral skills. When the consequences are reasonable, clear, and focused on correcting (not just punishing) inappropriate behavior, they can become an important part of an instructional program plan.

What are examples of rules that could potentially discriminate against specific students?

- Denying credit to students whose absences exceed the maximum permitted by the district when those absences are related to a disability. For example, a student with severe depression or anxiety may not be able to meet school attendance expectations for a period of time when the disability is not well managed.
- Attainment of a specific grade point average for a student to play in intramural or varsity sports, if the student's IEP or Section 504 team determines that the student is not able to meet the requirement. Some students with learning disabilities or emotional disorders may never be able to meet the grade expectation, unless the expectation is tailored to their individual needs.
- Suspension from school for irritating but not dangerous behaviors. Many annoying behaviors are poor behavioral habits. While suspensions are an emergency removal that may be necessary, that intervention will not teach students to become more reflective or less impulsive. Some behaviors are a result of impulsivity, or are unconsciously performed, such as tapping a pencil or humming. Still others are calculated and planned either to escape (avoid) something a youth does not want to do, or to gain something (such as peer attention) for the youth. Understanding the origins of a behavior is important in developing a planned response to the behavior. There is no sound educational basis for denying youth educational programming and related services necessary for them to benefit from their educational program, even during periods of emergency removal.

Are there instances when school suspension might serve as a positive reinforcement for some youth?

The repeated suspension of a student for non-dangerous behaviors such as truancy, tardiness, or insubordination may in fact represent a positive reinforcement for some students. If the student does not want to be in school, the use of suspension may well be teaching lessons about how to avoid responsibilities or how to obtain a "vacation" from school duties.

Increasingly, youth are being referred to the court systems for behaviors that are a manifestation of their disabilities. Frequently, those behaviors are not addressed constructively at the local school district level before a student is referred to the justice system. In one study, 50 percent of first time offenders were found to have previously unidentified learning disabilities (LDA, 1996). At times, students with a history of severe disruptive behaviors have been inappropriately expelled from their schools without being evaluated for learning, cognitive, or emotional disorders. A student with such a disorder might have responded well to an instructive, non-punitive educational program.

How can it be determined if inappropriate behaviors are a manifestation of a particular disability?

Under the IDEA, the inappropriate behaviors of a student with disabilities must be assessed by the IEP team to determine whether the behaviors are a manifestation of the disability. Consideration must be given to any medical, psychological or psychiatric reports that will assist in this determination. If the behaviors are determined to be a manifestation, the IEP team should develop an instructional plan to help the student learn acceptable alternative behaviors. The team must also consider if an individualized approach to behavior management will be needed to prevent repeated punishments for behaviors that have not shown improvement as a result of a punishment-based program.

One of the ways that school personnel can obtain information about how behaviors originate and are reinforced is through the use of a functional behavioral assessment (analysis). A functional assessment not only examines the frequency and intensity of a specific behavior, but also attempts to answer the fundamental question, "Why did the behavior occur?" Through a process of collecting data on a specific behavior or behaviors such as where the behavior occurred, events in the environment that might have contributed to the behavior, steps that were taken by adults to intervene with the behavior before it escalated, and determining whether the reinforcement a youth received following the behavior

could be seen as positive or negative, the evaluator attempts to answer the "Why" question. If it is possible to understand the conditions that led to or reinforced negative behavior, an IEP team can develop a proactive approach to helping a youth develop strategies to correct the behavior.

An example of a positive approach to teaching prosocial behavior skills would be a behavior plan that permits a youth to leave a classroom without consequence when he or she is becoming angry or anxious, and to report to a predetermined place until calm. This process is proactive because the intervention is used *before* the behaviors occur, and empowering because the responsibility for making the decision rests with the youth. Teaching youth how to manage their own behavior so that they can be successful in the world beyond the confinement of a juvenile facility is, of course, one of the responsibilities of a correctional placement. The services and due process procedures of IDEA have been designed to provide youth with disabilities access to appropriate learning experiences.

Chapter III

Promoting Family Involvement

Most studies confirm that maintaining family ties while youth are incarcerated and establishing positive family relationships correlate with a successful transition back into the community, and ultimately, with reduced recidivism.

Most studies confirm that maintaining family ties while youth are incarcerated and establishing or preserving positive family relationships correlate with a successful transition back into the community, and ultimately, with reduced recidivism (Dague & Tolin, 1996). Yet, according to one report (*Residential Facilities*, 1995), most surveys of correctional staff indicate that not enough is done to involve families.

Families often have a wealth of information about the youth that is important to professionals as they work with the youth throughout the justice process. This information, particularly as it relates to a youth's strengths and needs, can be valuable when justice and corrections personnel are making assessment decisions, programming and placement determinations and aftercare and transition plans. Also, the family is likely to be a part of the youth's life long after the role of justice professionals has ceased and can have an impact on the youth's future success.

Family involvement in the justice process can promote positive, long term outcomes for the youth and family, including:

1. The youth and family members will have made an investment in correctional planning and may feel ownership and commitment to follow through.
2. The youth and family members learn how to respond to situations and behaviors and how to resolve conflicts.
3. Family members maintain or strengthen their relationship with the youth, facilitating a successful transition home.

In order to participate meaningfully in juvenile justice processes, families of youth with disabilities need information about the juvenile justice system and how the system works, and their youth's rights to special education services and disability-specific accommodations. However, there are limited opportunities for families and professionals to effectively share valuable information about the youth in the juvenile justice system.

One process that does exist in which parental participation is required is in planning for a youth's special education program. Under IDEA, parents of students with disabilities, both in and out of the juvenile justice system, have the right to participate in decisions about their students' education (See Chapter II).

Despite the importance of, and legal requirement for, family participation in special education planning, families of youth in the justice system generally are underinvolved at all stages of the judicial process. Some things professionals can do to involve families include:

Under IDEA, parents of students with disabilities, both in and out of the juvenile justice system, have the right to participate in decisions about their students' education.

- Consult regularly and positively with families about the needs and progress of their youth who have been incarcerated. Parents have legal rights regarding educational planning for their children with disabilities. Also, involving parents in their youth's correctional program increases the likelihood of a successful transition back into the community for the youth.
- Consider the use of new technologies, such as telephone conferencing, to assist families in being informed and involved with their youth while in a correctional placement. Family attendance at meetings may not be possible due to lack of transportation, distance from home to the facility, cost of the trip, nontraditional work schedules, illness, disability, or child care issues. In addition, a youth's phone privileges may be restricted and, if the youth has communication disabilities, use of the telephone may be a challenge. A case manager, probation officer, social worker, counselor or other corrections staff may assist a family in overcoming these barriers.
- Youth who are wards of the state, or whose parents cannot be located, are legally entitled to a surrogate parent to act on their behalf in the area of special education program planning. The youth can benefit from the involvement of an advocate who cares about the youth and his or her educational program within the correctional setting.
- Family members of youth with disabilities in the justice system need access to, and regular progress reports on, all medical, mental health, and educational services their youth receives.
- Aftercare program planning with family, schools, corrections, and social services should begin well before a youth returns to the community, and coordination of the plan needs to be continued and monitored upon a youth's return to the community.

Parents may feel that because of their youth's alleged criminal behavior, they too are being judged by the school, the court and the community. For some parents, especially those who have disabili-

ties similar to their youth's, the youth's negative school experiences may mirror their own. Parents who may have experienced negative interactions with schools and service systems may be hesitant to work with some professionals. Other parents may simply have no experience working with professionals, may not know how to proceed or may become overwhelmed by the complexity of the system. Professionals can reach out to underinvolved families in the following ways:

1. Encourage parents to learn all they can about their youth's disability and what it might mean for the entire family. Refer them to a disability resource such as PACER Center in Minnesota or other parent centers (see list in Appendix) and encourage parent-to-parent contacts as sources of support and information.
2. Regard families as the experts they usually are by listening and acknowledging their insights about their youth, their experiences and feelings.
3. Consider families as allies in meeting the needs of the youth within a challenging system.
4. Avoid prejudgments of families and sincerely attempt to establish effective working relationships with them.
5. Develop an understanding of the distinct cultural behaviors of each family. Non-minority professionals may misperceive the behaviors of a culturally or racially diverse family. Seek cultural competency training and resources, if necessary.
6. Support parents in learning and applying consistent, appropriate discipline techniques that take into consideration the youth's disability.
7. Model and encourage parents to reinforce the youth's positive behaviors and accomplishments.
8. Encourage parents to be involved with and monitor their youth's activities and friends.
9. Facilitate parental involvement in their youth's education planning and help parents understand the importance of continuing involvement with schools as a way to model commitment to education for their youth.
10. Model and assist parents in learning how to work with educators, service providers and other professionals in setting goals and resolving issues related to their youth.
11. Provide information and resources regarding the juvenile justice adjudication process to parents, guardians, or surrogates in language they can understand.
12. Include information about court procedures, terminology, and timelines; the roles of families and professionals throughout the

process; the legal rights of the youth and his or her parents, including their rights to special education services and appeals processes; judicial standards regarding competency; and referrals to advocacy, disability, medical and counseling providers.

Chapter IV

Systems & Services: Looking to More Hopeful Responses

Systems' and Service Needs

"Everything about juvenile crime is harder to manage now. In the last week alone I've tried to find placement for three older teenagers with mental health problems and developmental delays. They mainly were in trouble because of stealing and drinking. But they're aggressive, so it's harder to find any placement that will take them, let alone one that has special programs. Sometimes insurance won't pay for what they need. It would be great if we could order a comprehensive assessment or work out a special treatment program in the community, but it's not realistic. There are not a lot of people out there to look out for these kids. That's why they get in trouble again and again."

There is a need for justice processes and correctional alternatives that meet the unique needs of youth, including disability-specific, mental health, racial, cultural and gender considerations.

The social worker who shared this reflection was expressing frustration with some of the difficulties working in the juvenile justice system. There are barriers within the juvenile justice system that make it more difficult for youth with disabilities to receive appropriate and meaningful correctional responses. The following needs have been identified:

1. Disability-specific information among attorneys, probation officers, judges and other personnel, including information regarding federal mandates for youth with disabilities.
2. A common, consistent and applicable evaluation, assessment, and testing standard for disabilities in the corrections system. Such standards must be flexible enough to address the unique cultural characteristics of the population.
3. Effective, collaborative coordination and integration of services among multiple systems serving a youth, including his or her family.
4. Justice processes that involve families of offenders, from a strength-based perspective, as stated in Chapter III.
5. Justice processes and correctional alternatives that meet the unique needs of youth, including disability-specific, mental health, racial, cultural and gender considerations.

6. Appropriate educational and functional skill attainment in correctional programs that meet state educational objectives.
7. Process to monitor, evaluate and report long-term outcomes for correctional programs, including recidivism and transitional successes.
8. Comprehensive, integrated, individualized aftercare programs, including formal and informal community supports to youth and their families.
9. Transition planning for returning to the home and community initiated well before a youth is released.
10. A comprehensive response to first-time youthful offenders, including disability, mental health, and other psychosocial assessments.

Recommendations for More Hopeful Responses

1. Rehabilitation, treatment, and functional, vocational and academic skill competencies should remain primary goals in developing appropriate consequences for youth in the juvenile justice system.

2. Depending on a youth's disability, he or she may benefit from a correctional and probationary approach that incorporates the concepts of restorative justice. That is, community-based efforts that bring offender and victim together to explore accountability, mediation and reparations.

3. Develop, implement and monitor a consistent screening process including:

    a. A "checklist" for attorneys to assist them in prescreening youth for possible assessments;

    b. An assessment tool that will be used statewide to identify young offenders in need of more comprehensive evaluations and possible special education services. This tool should incorporate self-reports and information from parents, educators and other people familiar with the youth.

4. Develop and implement an integrated interagency process for information sharing, based on data privacy standards, so that recommendations and decisions are based on a comprehensive, shared understanding of the individual.

5. Examine county, state and federal funding streams and initiate cost-comparisons with other approaches to juvenile violence and crime.

6. Before a case comes to trial, or after a youth is sentenced, there may be a significant time lag before he or she is remanded to a setting for the duration of their sentence. In some cases, a youth may move from one setting to another and a youth with disabilities may be without special education services for an extended (and legally out of compliance) period of time. Services should follow the youth.

7. A procedure should be integrated into the trial process that enables parents, surrogates or other advocates for an adjudicated youth to formally provide information about the youth's disability, his or her special education needs and other disability-specific accommodations.

8. More diversion and correctional programs should be developed to keep youth with disabilities in settings that are small, highly structured, treatment oriented and well supervised.

9. Information about the juvenile justice adjudication process should be provided to parents, guardians, or surrogates.

10. The state and counties should develop a database of programs for young offenders that are successful. Information about the strengths and weaknesses of these programs, based on program evaluations, would be made available to case managers, probation officers, attorneys, judges and social workers.

11. Correctional programs should develop comprehensive, integrated aftercare programs for offenders when they leave a correctional program and reenter the community, with information and support to a youth's family, school and vocational setting.

12. Ongoing training should be mandatory for professionals including attorneys, judges and probation officers regarding the characteristics of the disabilities most common in young offenders, how to determine whether special education services are warranted, and how to identify those correctional programs that might be most effective for youth with disabilities.

13. Preservice and inservice disability training for foster care providers of therapeutic programming and staff working in correctional programs with youth whom have disabilities.

14. Provide federal and state funding to Parent Training and Infor-

mation Centers (see Appendix) to educate parents about the juvenile justice system. Additionally, families of youth in the juvenile justice system should be made aware of resources such as Parent Training and Information Centers and disability law centers in each state that could assist them in understanding and acquiring the services to which their child with a disability is entitled. Advocates knowledgeable in both educational and juvenile justice systems should be hired to assist families supporting their youth across systems. This should include information about accessing an appeals process for special education services through the Department of Corrections or Department of Education.

15. Communities should encourage and develop partnerships between the public and private sectors to provide employment, skills training and volunteer opportunities for youth with disabilities.

16. Cultural competency training should be strengthened and included in orientation of all staff who work with populations of culturally and racially diverse youth, including staff in law enforcement, corrections settings, probation, social work and the legal profession.

17. Develop and implement a comprehensive crime prevention program targeting youths with disabilities engaged in at-risk behaviors or early criminal involvement and their families. Ideally, this program should be implemented before middle school. Strategies include addressing parent training needs; improving communication with parents and educators; meeting special education needs (where appropriate); increasing functional vocational, academic and social skills; developing conflict resolution and problem- solving skills; and developing skills that promote insight and accountability.

18. State departments of education and corrections might consider creating an appointed director of special education position with responsibility for all state- and county-administered correctional facilities and residential treatment facilities. The director would be responsible for providing staff training on special education law, for monitoring and compliance, and for promoting the development of educational, psychosocial and vocational services to meet the needs of offenders with disabilities.

Conclusion

Youthful offenders bring a unique set of needs into the justice system. Moreover, youth with disabilities have needs requiring even more specialized approaches. Historically, a mission of the juvenile justice system was to ensure that youth were judged in an environment that recognized and considered a youth's unique culpability and rights. Rehabilitation of the youthful offender was considered an inviolable goal of correctional consequences. However, as the number and severity of youth crimes increased, the system mandate has shifted toward punitive approaches. These have been shown to be largely ineffective. In fact, studies indicate that harsh penalties actually increase the likelihood for criminals to re-offend as well as commit crimes of a more serious nature (Cannon, 1997).

There is no one formula for developing effective correctional approaches and consequences to reduce youth crime and recidivism.

As yet, there is no *one* formula for developing effective correctional approaches and consequences to reduce youth crime and recidivism. The interrelation of a range of potential risk factors may impact a youth's attainment of emotional health, prosocial skills, positive educational experiences and life skill competencies. The disability itself is one unique risk factor, particularly if it has not been identified early and has not been addressed with effective interventions. Coupled with poverty, abuse and neglect, and other risks, the impact of a disability on a youth's opportunities for success is compounded.

For youth with disabilities, the IDEA and the ADA ensure that those who qualify are entitled to special education in correctional programming and disability-specific accommodations in justice processes. Furthermore, multisystemic approaches in corrections can bring families and multidisciplinary professionals together to address each youth's unique strengths and needs.

It is not necessary, nor feasible, for all persons working with youth in the justice system to become proficient in disability identification and accommodation. However, with increased awareness about disabilities and risk factors common among juvenile offenders, professionals will be better able to contribute to more meaningful outcomes for the offender. For more information on these and other disabilities, see the Appendix for a list of Minnesota and national disability organizations or contact PACER Center.

Appendix

Resource List of National Organizations Related to Youth and Juvenile Justice

American Bar Association
Center on Children and the Law
740 15th St. NW 9th floor
Washington, DC 20049
202-662-1720

Bureau of Justice Assistance Clearinghouse
PO Box 6000
Rockville, MD 20850
800-688-4252
Web page: www.ojp.usdoj.gov/BJA/

Bureau of Justice Statistics Clearinghouse
PO Box 6000
Rockville, MD 20850
800-723-3277
Web page: www.ojp.usdoj.gov/bjs/

CDC Youth Violence Evaluation Project
Division of Violence Prevention
Centers for Disease Control and Prevention
4770 Buford Hwy NE
M/S K60
Atlanta, GA 30341-3724
404-488-464(

Center for the Study and Prevention of Violence
Institute of Behavioral Science
University of Colorado at Boulder
Campus Box 442
Boulder, CO 80309-0442
303-492-1032

Child Welfare League of America
440 First St. NW Suite 310
Washington, DC 20001
202-638-2952

Children's Defense Fund
25 E Street NW
Washington, DC 20001
202-628-8787

Coalition for Juvenile Justice
1211 Connecticut Ave. NW Suite 414
Washington, DC 20036
202-467-0864

Department of Justice
ADA Information Line
800-514-0301, Voice
800-514-0383, TTY

Family Violence Prevention Center
383 Rhode Island St. Suite 304
San Francisco, CA 94103
415-252-8900

Juvenile Justice Clearinghouse
PO Box 6000
Rockville, MD 20850
800-638-8736

Juvenile Law Center
801 Arch St. Suite 610
Philadelphia, PA 19107
215-625-0551

National Center for Juvenile Justice
710- 5th Ave. 3rd Floor
Pittsburgh, PA 15219
412-227-6950

National Clearinghouse on Families and Youth
PO Box 13505
Silver Spring, MD 20911-3505
800-621-4000

National Committee to Prevent Child Abuse
332 So. Michigan Ave. Suite 1600
Chicago, IL 60604
312-663-3520

National Council on Crime and Delinquency
685 Market St. Suite 620
San Francisco, CA 94105
415-896-6223

National Crime Prevention Council
1700 K St. NW 2nd Floor
Washington, DC 20006-3817
202-466-6272

National Criminal Justice Reference Service (NCJRS)
PO Box 6000
Rockville, MD 20850
800-851-3420
Web page: www.ncjrs.org/ncjhome.htm

National Institute for Citizen Education in the Law
711 G St. SE
Washington, DC 20003
202-546 6644

National Juvenile Detention Association
301 Perkins Building
Richmond, KY 40475
606-622-6259

National Legal Resource Center for Child Welfare Services
740 15th St. NW 9th floor
Washington, DC 20005
202-662-1748

National School Safety Center
4165 Thousand Oaks Blvd. Suite 290
Westlake Village, CA 91362
805-373-9977

Office of Juvenile Justice and Delinquency Prevention
633 Indiana Ave. NW
Washington, DC 20531
202-307-5924
Web page: www.ncjrs.org/ojjhome.htm

Youth Law Center
114 Sansome St. Suite 950
San Francisco, CA 94104
415-543-3379

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Parent Training and Information Centers

The following is a list of the Parent Training and Information Centers (PTIs) that serve families of children and adults with disabilities throughout the U.S. The list is accurate as of this writing; however, the information does change frequently. For updates on any of the PTIs, call PACER or visit PACER's Web site (www.pacer.org).

Alaska

P.A.R.E.N.T.S. Resource Center
540 International Road, Suite 200
Anchorage AK 99518
(907) 563-2246 Voice & TTY
800-478-7678 in AK
E-mail: parents@alaska.net
Web site: http://www.alaska.net/~parents/@alaska.net

Alabama

Special Education Action Committee, Inc.
P.O. Box 161274
3207 International Drive, Suite C
Mobile AL 36616-2274
(334) 478-1208 Voice & TTY
800-222-7322 AL only
E-mail: seacmob1@juno.com

Arkansas

Arkansas Disability Coalition
3920 Woodland Heights Road
Little Rock AR 72212
(501) 221-1330 Voice & TTY
800-223-1330 AR only
E-mail: adc@cei.net

American Samoa

American Samoa PAVE
P.O. Box 3432
Pago Pago AS 96799
011-(684) 633-2407

Arizona

Pilot Parent Partnerships
4750 N. Black Canyon Hwy, Suite 101
Phoenix AZ 85017-3621
(602) 242-4366 Voice & TTY
800-237-3007 in AZ

California

Parents Helping Parents
3041 Olcott St.
Santa Clara CA 95054-3222
(408) 727-5775 Voice / 408-727-7655 TTY
E-mail: maryellen@php.com
Web site: http://www.php.com

TASK
100 West Cerritos Ave.
Anaheim CA 92805-6546
(714) 533-8275
E-mail: taskca@aol.com

Family Network of CA
594 Monterey Blvd.
San Francisco CA 94127-2416
(415) 841-8820

Exceptional Parents Unlimited
4120 N. First St.
Fresno CA 93726
(209) 229-2000
E-mail: etu1@cybergate.com

TASK, San Diego
3750 Convoy St., Suite 303
San Diego CA 92111
(619) 874-2386

Support for Parents
2601 Mission #710
San Francisco CA 94110-3111

Colorado

PEAK Parent Center, Inc.
6055 Lehman Drive, Suite 101
Colorado Springs CO 80918
(719) 531-9400 / (719) 531-9403 TTY
800-284-0251
E-mail: PKPARENT@aol.com

BEST COPY AVAILABLE

Connecticut

CPAC
5 Church Lane, Suite 4
P.O. Box 579
East Lyme CT 06333
(860) 739-3089 Voice & TTY
800-445-2722 in CT
E-mail: cpacinc@aol.com
Web site: http://members.aol.com/cpacinc/cpac.htm

District of Columbia

COPE
300 I Street NE, Suite 112
Washington DC 20002
(202) 543-6482
1-800-515-COPE (National)

Delaware

Parent Information Center (PIC)
700 Barksdale Road, Suite 3
Newark DE 19711
(302) 366-0152 / (302) 366-0178 (TTY)
E-mail: PEP700@aol.com

Florida

Family Network on Disabilities
2735 Whitney Road
Clearwater FL 34620-1610
(813) 523-1130
800-825-5736 FL only
E-mail: fnd@gate.net
Web site: http://www.gate.net/~fnd

Georgia

Parents Educating Parents (PEP)
8318 Durelee Lane Ste 101
Douglasville GA 30134
(770) 577-7771
E-mail: PEPARC@aol.com

Hawaii

AWARE
200 N. Vineyard Blvd., Suite 310
Honolulu HI 96817
(808) 536-2280 / (808) 536-9684 (Voice & TTY)

Idaho

Idaho Parents Unlimited, Inc.
4696 Overland Road, Suite 478
Boise ID 83705
(208) 342-5884 Voice & TTY
800-242-4785
E-mail: ipul@rmci.net

Illinois

Family Resource Center on Disabilities
20 E. Jackson Blvd., Room 900
Chicago IL 60604
(312) 939-3513 / (312) 939-3519 TTY
1-800-952-4199 IL only

Designs for Change
6 North Michigan Ave., Suite 1600
Chicago IL 60602
(312) 857-9292; (312) 857-1013 TTY
1-800-851-8728
E-mail: dfc1@aol.com

National Center for Latinos with Disabilities
1921 South Blue Island
Chicago IL 60608
312-666-3393; TTY 312-666-1788
E-mail: ncld@interaccess.com

Family T.I.E.S. Network
830 South Spring
Springfield IL 62704
217-544-5809
800-865-7842
E-mail: ftiesn@aol.com

Indiana

IN*SOURCE
809 N. Michigan St.
South Bend IN 46601-1036
(219) 234-7101
800-332-4433 in IN
E-mail: insource@inspeced.ccmail.compuserve.com

Iowa

Contact PACER for information.

Kansas

Families Together, Inc.
3340 W Douglas, Ste 102
Wichita KS 67203
(316) 945-7747
1-888-815-6364
E-mail: family@inlandnet.net

Kentucky

Family Training & Information Center
2210 Goldsmith Lane, Suite 118
Louisville KY 40218
(502) 456-0923 or 800-525-7746
800-525-7746
E-mail: fraeme@msn.com

Louisiana

Project PROMPT
4323 Division Street, Suite 110
Metairie LA 70124-3179
(504) 888-9111
800-766-7736
E-mail: fhfgno@ix.netcom.com

Massachusetts

Federation for Children with Special Needs
95 Berkeley St., Suite 104
Boston MA 02116
(617) 482-2915 (Voice & TTY)
800-331-0688 in MA
E-mail: zieg104w@wonder.em.cdc.gov
Web site: http://www.fcsn.org/

Maryland

Parents Place of Maryland, Inc.
7257 Parkway Drive, Suite 210
Hanover MD 21076-1306
(410) 712-0900 Voice & TTY
E-mail: parplace@aol.com

Maine

Special Needs Parents Information Network
P.O. Box 2067
Augusta ME 04338-2067
(207) 582-2504
800-870-SPIN in ME
E-mail: lachance@saturn.caps.maine.edu

Michigan

CAUSE
3303 W. Saginaw, Suite F-1
Lansing MI 48917-2303
(517) 886-9167 Voice & TTY
800-221-9105 in MI
E-mail: cause@ix.netcom.com

Parents Are Experts
23077 Greenfield Road, Suite 205
Southfield MI 48075-3744
(248) 557-5070 Voice & TTY
E-mail: ucpdetroit@aol.com

Minnesota

PACER Center, Inc.
4826 Chicago Avenue South
Minneapolis MN 55417-1098
(612) 827-2966 (Voice); (612) 827-7770 (TTY)
800-537-2237 in MN
E-mail: mnpacer@edu.gte.net
Web site: http://www.pacer.org

Missouri

Missouri Parents Act
2100 S. Brentwood, Suite G
Springfield MO 65804
(417) 882-7434 (TTY)
800-743-7634 in MO
E-mail: mpac01@MCIONE.com

Mississippi

Parent Partners
3111 North State St.
Jackson MS 39216
601-366-5707
800-366-5707
E-mail: ptiofms@misnet.com

Montana

Parents Let's Unite for Kids (PLUK)
1500 North 30th St., Room 183
Billings MT 59101-0298
(406) 657-2055
800-222-7585 in MT
E-mail: PLUKMT@aol.com

North Carolina

ECAC, Inc.
P.O. Box 16
Davidson NC 28036
(704) 892-1321
800-962-6817 NC only
E-mail: ECAC1@aol.com

North Dakota

Pathfinder Family Center
Arrowhead Shopping Center
16th St. and 2nd Ave. SW
Minot ND 58701
(701) 852-9426 / (701) 852-9436 TTY
E-mail: ndpath01@minot.ndak.net
Web site: http://www.ndcd.org/pathfinder

Nebraska

NE Parents' Information & Training Center
3610 Dodge St., Suite 102
Omaha NE 68131
(402) 346-0525 Voice & TTY
800-284-8520

New Hampshire

Parent Information Center
P.O. Box 2405
Concord NH 03302-2405
(603) 224-7005 (Voice & TTY)
800-232-0986 (NH only)
E-mail: picnh@aol.com

New Jersey

Statewide Parent Advocacy Network (SPAN)
35 Halsey Street, 4th Floor
Newark NJ 07102
(973) 642-8100 Voice
800-654-SPAN
E-mail: autind@aol.com

New Mexico

EPICS Project
P.O. Box 788
Bernalillo NM 87004
(505) 867-3396, ext. 109
800-765-7320 V/TTY
E-mail: swcrathighfiver.com

Parents Reaching Out, Project ADOBE
1000-A Main St. NW
Los Lunas NM 87031
(505) 865-3700 Voice & TTY
800-524-5176 in NM

Nevada

Nevada Parents Encouraging Parents (PEP)
6910 Edna Avenue
Las Vegas NV 89117-3004
(702) 248-6711
800-216-5188
E-mail: nvpep@wizard.com

New York

Parent Network Center
250 Delaware Avenue, Suite 3
Buffalo NY 14202
(716) 853-1570; (716) 853-1573 TTD
800-724-7408 in NY

Advocates for Children of NY
105 Court Street, Ste. 402
Brooklyn NY 11201
(718) 624-8450
E-mail: advocat1@idt.com

Resources for Children with Special Needs
200 Park Ave. S., Suite 816
New York NY 10003
(212) 677-4650
E-mail: vzhe93a@prodigy.com
Web site: http://www.epsty.com/resourcesnyc

Sinergia/Metropolitan Parent Center
15 West 65th St., 6th Floor
New York NY 10023
212-496-1300
E-mail: Sinergia@panix.com
Web site: http://www.panix.com/~sinergia

Ohio

Child Advocacy Center
1821 Summit Road, Suite 303
Cincinnati OH 45237
(513) 821-2400
E-mail: CADCenter@aol.com

Ohio Coalition for the Education of Children with Disabilities
Bank One Building
165 West Center St., Suite 302
Marion OH 43302-3741
(614) 382-5452 Voice & TTY
800-374-2806
E-mail: ocecd@edu.gte.net

Oklahoma

Parents Reaching Out in OK
1917 S. Harvard Avenue
Oklahoma City OK 73128
(405) 681-9710
800-PL94-142
E-mail: prook1@aol.com

Oregon

Oregon COPE Project
999 Locust St. NE, Box B
Salem OR 97303
(503) 581-8156 Voice & TTY
E-mail: cope@mail.ncn.com

Pennsylvania

Parents Union for Public Schools
311 S. Juniper St., Suite 602
Philadelphia PA 19107
(215) 546-1166
E-mail: ParentsU@aol.com

Parent Education Network
333 East Seventh Avenue
York PA 17404
(717) 845-9722 (Voice & TTY)
800-522-5827 in PA
E-mail: pen@cyberia.com

Puerto Rico

Parents Training Parents by APNI
P.O. Box 21301
San Juan PR 00928-1301
(787) 763-4665 / 765-0345 (Phone & FAX)
E-mail: APNIPR@PRTC.net

Rhode Island

RI Parent Information Network
500 Prospect Street
Pawtucket RI 02860
(401) 727-4144 / (401) 727-4151 TTY
800-464-3399 in RI

South Carolina

PRO-PARENTS
2712 Middleburg Drive, Suite 102
Columbia SC 29204
(803) 779-3859 Voice & TTY
800-759-4776 in SC
E-mail: pro-parents@aol.com

South Dakota

South Dakota Parent Connection
3701 West 49th St., Suite 200B
Sioux Falls SD 57106
(605) 361-3171 Voice & TTY
800-640-4553 in SD
E-mail: sdparent@connection.com
Web site: http://dakota.net/sdpc

Tennessee

STEP
424 E. Bernard Ave., Suite 3
Greeneville TN 37745
(423) 639-0125 / 636-8217 TTY
800-280-STEP in TN
E-mail: tnstep@aol.com

Texas

Partners Research Network Inc.
1090 Longfellow Drive, Suite B
Beaumont TX 77706-4889
(409) 898-4684 Voice & TTY
800-866-4726 in TX
E-mail: TXPRE@juno.com
Web site: http://www.salsa.net/~path

Project PODER
1017 N. Main Ave., Suite 207
San Antonio TX 78212
(210) 222-2637
800-682-9747 TX only

BEST COPY AVAILABLE

Utah

Utah Parent Center
2290 East 4500 S., Suite 110
Salt Lake City UT 84117
(801) 272-1051
800-468-1160 in UT
E-mail: upc@inconnect.com

Virginia

Parent Educational Advocacy Training Center
10340 Democracy Lane, Suite 206
Fairfax VA 22030
(703) 691-7826
800-869-6782 VA only
E-mail: peatcinc@aol.com
Web site: http://members.aol.com/peatcinc/index.htm

Virgin Islands

V.I. FIND
#2 Nye Gade
St. Thomas USVI 00802
(340) 775-3962

Vermont

Vermont Parent Information Center
1 Mill Street, Suite A7
Burlington VT 05401
(802) 658-5315 Voice & TTY
800-639-7170 in VT
E-mail: vpic@together.net
Web site: http://www.together.net/~vpic

Washington

Washington PAVE
6316 South 12th
Tacoma WA 98465-1900
(253) 565-2266 (Voice & TTY)
800-572-7368 in WA
E-mail: wapave9@idt.net
Web site: http://idt.net/~wapave9

PAVE/STOMP
10209 Bridgeport Way SW #A5
Tacoma WA 98499
(253) 588-1741 Voice & TTY
800-298-3543
E-mail: wapave9-2@idt.net
Web site: http://idt.net/~wapave9

Wisconsin

Parent Education Project of Wisconsin
2192 South 60th Street
West Allis WI 53219-1568
(414) 328-5520 Voice; (414) 328-5525 TTY
800-231-8382 (WI only)
E-mail: colletti@omnifest.uwm.edu

West Virginia

West Virginia PTI
371 Broaddus Ave
Clarksburg WV 26301
(304) 624-1436 Voice & TTY
800-281-1436
E-mail: wvpti@aol.com

Wyoming

Wyoming PIC
5 North Lobban
Buffalo WY 82834
(307) 684-2277 Voice & TTY
800-660-9742 WY only
E-mail: tdawsonpic@vcn.com